THE EFFECT OF CHILD-CENTERED PLAY THERAPY ON THE EXTERNALIZING BEHAVIORS OF LOW INCOME MALE PRESCHOOLERS DURING GROUP INSTRUCTIONAL TIME AND CENTER TIME: A SINGLE-CASE DESIGN STUDY

by

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ABSTRACT

CHRISTA BROWN PHIPPS. The Effect Of Child-Centered Play Therapy on the Externalizing Behaviors of Low Income Male Preschoolers During Group Instructional Time and Center Time: A Single-Case Design Study (Under the direction of DR. PHYLLIS POST)

Low income male preschoolers with externalizing behaviors have continued behavior issues throughout elementary school, middle school, high school, and into adulthood and create stress for their teachers. Because of this, it is important to detect externalizing behaviors early and implement an appropriate intervention. A single subject reversal design was used to examine the effects of child-centered play therapy (CCPT) on the externalizing behaviors of five low income male preschoolers during group instructional time and center time who scored the highest on the Externalizing Subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form for Ages 1½ - 5 (C-TRF 1.5-5; Achenbach & Roscorla, 2001). These five children were observed and assessed twice a week on the Externalizing Subscale of the C-TRF by two blind observers. The child with the highest score on the C-TRF 1.5-5 (Student A) completed the reversal design, which included 21 thirty-minute play therapy sessions. The results of this study showed a functional relation between CCPT and externalizing behaviors with this child. The study also indicated that as this child began the intervention and his externalizing behaviors decreased, the other four male students' externalizing behaviors decreased as well.

DEDICATION

Above all things, I want to thank Jesus Christ, my Lord and savior. He is referred to as "Wonderful Counselor" in the gospels and his life, death and resurrection informs all that I do. It is through his calling that I initiated this journey and he has sustained me throughout every moment. Second, I want to thank my wonderful husband who has sacrificed willingly and with joy. You possess a strength that has allowed me to lean on you in every moment of this journey. I thank you for loving me as Christ has loved the church and demonstrating the gospel through our marriage. Third, I thank my wonderful daughters. You are my heart. I know these last three plus years have not always been easy. You have given me the gift of patience and have stepped up to allow me time to complete this journey. Fourth, I want to thank my parents. You instilled in me a force that is unstoppable and a faith that is unshakable. Fifth, I want to thank my workout partner, Holly, for putting up with all those early morning rants and cries. You have stuck this out and always supported this journey. Last, and specifically to my mother, you are the teacher that every child needs. I have seen you go over and beyond to be of assistance to the children who have been in your classroom. You have looked past the behaviors and touched the lives of so many children. Your courage and faith throughout your life and particularly the last 14 years has strengthened my faith and showed me the true nature of a Christian.

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CHAPTER 1: INTRODUCTION

The behaviors of juveniles in the United States have become a major issue for society. Aggressive and hyperactive behaviors by juveniles are shown to be a drain on mental health services and a menace to society (Committee on School Health, 2004). "Seventeen percent of all serious violent crimes reportedly involved a juvenile offender" (Federal Interagency Forum on Child and Family Statistics, 2015, p. 45). The serious violent crimes in this report included aggravated assault, rape, robbery, and homicide. However, the report suggested that these numbers are conservative and suspected the percentage is higher. Aggressive behaviors were not the only problem found that were challenging to society. In a different national survey concerning juveniles, 7% of children between the ages of 3-17 were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) with boys being twice as likely to be diagnosed as girls (Bloom & Cohen, 2009).

Aggressive and hyperactive behaviors typically begin in childhood. In a review of the literature of 30 research reports, it was found that 30% of children in the low-income population exhibit behavior disturbances significant enough to disrupt their functioning in the home, at school, and in the community (Qi & Kaiser, 2003). However, children do not have to have a diagnosis for behaviors to be a problem. Angold, Costello, Farmer, Burns, and Erkanli (1999) examined 1,015 school-aged children for psychosocial impairment and found that 140 children had a diagnosis and impairment, 143 children had a diagnosis only, and 205 children had impairment. The study concluded that

children with impairment did not meet the diagnostic criteria for any disorder; however, these children still had issues that affected their behavior.

These disturbing behaviors in school-aged children have been traced as far back as kindergarten. Teachers reported that 10 to 11% of kindergartners exhibited aggressive behaviors, and 20% were considered to be hyperactive (U. S. Department of Education, 2000). In that study aggressive behaviors were defined as fighting and arguing with peers and teachers as well as becoming angry easily, while hyperactivity was defined as being more active than peers. The children with these behaviors exhibited poor social-emotional development in the classroom. Boyd, Barnett, Bodrova, Leong, and Gomby (2005) defined poor social development as the inability to pay attention, remember information, and interact socially with others.

Hyperactivity and aggressive behaviors are normally apparent before a child begins kindergarten. Around 32% of low-income children in Head Start programs exhibited behavioral problems (Boyd et al., 2005). While it is expected that preschool children have some behavior problems, high, persistent aggression in preschoolers (specifically for boys) was an indicator for continued violence and other behavior issues throughout adolescence and adulthood and a significant predictor of negative academic performance at age 7.5-years (Brennan, Shaw, Dishion, & Wilson, 2012; Broidy, et al., 2003). Preschool has been considered a time when children build the foundation for their education and learn to self-regulate their emotions. (Curby, Brown, Bassett, & Denham, 2015). Preschoolers who exhibited aggressive and hyperactive behaviors have trouble navigating this journey due to the teachers' perceptions that they do not possess the

ability to focus on learning (Graziano, Reavis, Keane, & Calkins, 2007). As a consequence, these children with hyperactivity and aggression were less likely to learn the core academic skills needed for elementary school (Barkley, 2003).

Hyperactive and Aggressive Behaviors as Externalizing Behaviors

Preschoolers who cannot learn core academic skills, regulate their emotions, and/or cause stress for those around them begin their education with a deficit. This is why it is imperative for these aggressive and hyperactive behaviors to be detected early by educators and mental health professionals. Caprara, Dodge, Pastorelli, and Zelli (2007) addressed this issue in their theory of marginal deviation which suggested that initial deviant behavior would transform into more serious antisocial behavior. The findings indicated that out of the total population, one-third exhibited marginally deviant behavior. Out of this one-third, one-fourth of this marginally deviant population became seriously deviant over time. This translated to around 8% of the total population becoming seriously deviant. They note that when children's behaviors reached the point that it caused discomfort and distress to those around them, the adults (i.e. parents and teachers) and peers began to validate and sustain the behaviors over time. Once the adults and peers began to validate and sustain the behaviors, children entered into a cycle that was very hard to break with adults and peers. It proposed that a self-fulfilling prophecy contributed to this cycle.

Because of the self-fulfilling prophecy, children who exhibit continued aggressive and hyperactive behaviors in preschool would continue to have issues throughout school and into adulthood. These behaviors in early childhood can lead to serious future

concerns such as poor social skills, delinquency, consistent academic underachievement, peer rejection, deviant peer relationships, the need for special services, school dropout, and substance abuse (Campbell, Spieker, Burchinal, Poe, & The NICHED ECCRN, 2006; Chen, McComas, Hartman, & Symons, 2011; Moilanen, Shaw, & Maxwell, 2010; Wilson & Marcotte, 1996). This is why it is imperative to address this problem when children are young.

The negative effects of the self-fulfilling prophecy and the children's hyperactive and aggressive behaviors also affected their parents, peers, and teacher. The Child Behavior Checklist (CBCL; Achenbach, 1991) was designed to assess the degree of aggressive and hyperactive behaviors, or externalizing behaviors, which are defined as behavior problems that negatively affect the child's external environment, such as home, community, or school (Campbell, Shaw, & Gilliom, 2000; Eisenberg et al., 2001).

The Effects of Externalizing Behaviors on Teachers

Externalizing behaviors also affect the way teachers view children. Children who exhibited externalizing behaviors caused significant stress to the teacher and were more frustrating to teach (Green, Beszterczey, Katzenstein, Park, & Goring, 2002). This was, in part, because the teacher had to transfer classroom support to the child who was exhibiting behavior difficulties, essentially discounting the children who are not experiencing behavior difficulties (Thijs, Kooman, & van der Leij, 2006). Teachers' perception of child externalizing behaviors increased teacher stress (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014), and teacher stress was associated with teacher emotional exhaustion and burnout (Jennings & Greenberg, 2009), which affected

classroom emotional climate (Downer, Sabol, & Hamre, 2010). All these factors led to a negative student-teacher relationship, which raised teacher stress, led to the self-fulfilling prophecy where the children were labeled as unteachable throughout elementary, middle, and high school, and negatively affected the academic trajectory of the children (Caprara et al., 2007; Green, Abidin, & Kmetz, 1997).

Students' behaviors do not seem to be the only factor that affects a teacher's perception. There also seems to be a relationship between students' gender, and socioeconomic status (SES) and teachers' view of students' behaviors (U. S. Department of Education, 2000). Teachers reported that low-income children could be extremely stressful to teach because they were more likely to exhibit behavioral and academic problems (Zhai, Raver, & Li-Grining, 2011). Behavioral and academic problems could be a result of stressful factors, such as parenting and attachment issues, encountered by children from low SES (Qi & Kaiser, 2003). These factors make it hard to trust adults and to concentrate on school work.

The Effects of Externalizing Behavior on Parents

Children's externalizing behaviors not only affect teachers' perceptions, but also affect parent's perceptions. Parent's perceptions about their children are difficult to change once the children's behaviors reach the point of discomfort for those around them. These perceptions contribute to the self-fulfilling prophecy. For example, Speltz, DeKlyen, and Greenberg (1999) used the CBCL (Achenbach, 1991) to measure externalizing behaviors over a three year time period using a sample of preschool boys. Eighty boys scored 65 or above on the CBCL, as reported by parents. A year later, 73

boys were available from the sample. Fifty-two (71%) of these boys met the diagnostic criteria for Oppositional Defiant Disorder (ODD) or ADHD. Two years later, when they entered school, 69 boys were available and 51 (74%) met the diagnostic criteria for either ODD or ADHD. This speaks to the fact that externalizing behaviors are persistent and parents' opinions do not change much over time so it is important to address and intervene in externalizing behavior concerns early.

In another study, parents of 300 low-income preschool boys from families with high stress and poor parenting behaviors did not change their view of externalizing behaviors of their children over time (Shaw, Gilliom, & Giovannelli, 2000). Using the CBCL (Achenbach, 1991), parents reported that 6% of the sample of boys had clinically elevated levels of externalizing behaviors above the 90th percentile in preschool. Out of the boys who scored at the clinical level in preschool, parents reported 63% of the boys remained at the 90th percentile at year later at age five. Parents reported 62% remained in the clinical range two years later at age six indicating that parents' views of the boys' externalizing behavior did not change over a two-year period. These two studies reiterated the importance of intervening early to reduce externalizing behaviors in low-income boys.

The Effects of Externalizing Behaviors on Peers

Children who exhibit externalizing behaviors also experience rejection from friends. There was a significant relationship between children's externalizing behavior and peer rejection by the end of the school year (Chen et al., 2011). This same study found that externalizing behaviors and peer rejection seemed to be a vicious circle that

increased as the school year continued lead to the self-fulfilling prophecy discussed by Caprara et. al. (2007). Symptoms of ADHD at age 4-years significantly predicted increased peer rejection at age 6-years, and peer rejection at age 4-years negatively affected hyperactive, inattentive, and impulsive symptoms at ages six and 8-years (Stenseng, Belsky, Skalicka, & Wichstrom, 2016). Peer rejection causes a self-fulfilling prophecy and leads to conduct problems later in life (Caprara et. al., 2007; Chen et al., 2011; Leary & Katz, 2005). These studies further demonstrated the need for an early intervention for preschool children before the cycle of peer rejection begins.

To address the social-emotional development and children's mental health, the major types of psychotherapy for children include supportive, psychodynamic, cognitive-behavioral, interpersonal, and family systemic therapy (U. S. Department of Health and Human Services, 1999). Presently, behavior management therapies and parent training are still considered well-established evidenced based treatments for aggression and hyperactivity in children (Society of Clinical Child and Adolescent Psychology, Committee on Evidence-Based Practice, & Network on Youth Mental Health, 2016). However, the 1999 report admitted that these therapies were created for adults and modified. They are only considered effective because the child has greater improvements with treatment when compared to no treatment. Child-centered play therapy (CCPT) is a more developmentally appropriate option for a young child, is widely recognized, and is considered an effective therapeutic intervention when working with children with externalized behaviors (Garza & Bratton, 2005; Ray, 2007). CCPT also assists in

reducing teacher stress by helping children regulate their emotions (Ray, Henson, Schottelkorb, Brown, & Muro, 2008).

Child-Centered Play Therapy

Tenets of Child-Centered Play Therapy

Research indicates that the effectiveness of CCPT in reducing externalizing behaviors came from the child working through emotional disturbances (Axline, 1947). In CCPT, the relationship is the conduit for positive change and the child learns to regulate emotions, solve problems, works through issues, and to face problems with confidence (Landreth, 2012; Raskin & Rogers, 2005). Axline's (1947, pp. 73-74) eight guiding principles embrace tenets that focus on this relationship and include:

1. Developing a warm, friendly relationship with the child.
2. Accepting the child exactly as he/she is.
3. Facilitating an atmosphere of permissiveness so that the child is free to express his/herself.
4. Recognizing and reflect the child's feelings in order to help him/her gain insight into his/her own behavior.
5. Honoring the child's inherent capacity to solve his/her own problems.
6. Allowing the child to direct therapy.
7. Understanding that therapy is a gradual process and should not be hurried.
8. Establishing only those limits necessary to ground the child in the world of reality and make the child aware of his/her responsibility within the therapeutic relationship.

Landreth (2012) built significantly upon Axline's eight guiding principles of play therapy. For the purposes of this study, Landreth's CCPT philosophy and techniques will be used. Landreth agrees with Piaget (1962) in that he asserts that play is fundamental to a child's emotional, social, and cognitive development. Thus, Landreth views the child as an individual with the capacity for growth; therefore, the child is the focus of therapy, not the problem. Therapists create a safe environment for children to communicate feelings, thoughts, and needs (Bratton, Ray, Edwards, & Landreth, 2009). Landreth believes children use play to communicate and to work through issues much the same way adults use words. This accepting environment enables the child to experience self-direction toward growth, emotional health, and behavioral change (Bratton, Ray, Edwards, & Landreth, 2009; Bratton, Ray, & Landreth, 2008).

Child-Centered Play Therapy as an Effective Intervention

Social-emotional development is crucial for young children because it lays the foundation for later life outcomes. Without good social-emotional development, children were more at risk for aggressive behavior, poor learning outcomes, and criminal behavior later in life (Boyd et al., 2005). Child-centered play therapy has been shown to be a culturally sensitive intervention that has assisted in social-emotional development for children in school (Landreth, Ray, & Bratton, 2009). School aged children with disruptive behaviors showed significant improvements on the Externalizing Subscale of the Teacher Report Form after CCPT (Cochran, Cochran, Fuss, & Nordling, 2010). School aged children with Attention Deficit Disorder (ADHD) demonstrated significant reduction in ADHD symptoms on the Index of Teaching Stress, thus reducing teacher

stress (Ray, Schottelkorb, & Tsai, 2007). Child-centered play therapy was shown to be effective with low-income children attending Title I schools. At risk fourth, fifth, and sixth graders maintained an internal locus of control and self-esteem scores after CCPT was implemented (Post, 1999). In addition, elementary school aged African American males demonstrated an increase in their self-concept, attention and helpfulness in the classroom significantly after receiving CCPT (Baggerly & Parker, 2005), and Hispanic elementary school aged students had a significant reduction in externalizing behaviors after 15 sessions of CCPT when compared to a curriculum-based group intervention (Garza & Bratton, 2005).

Child-centered play therapy has also been shown to be an effective intervention with preschoolers. Bratton et al. (2013) conducted a study that examined the effectiveness of CCPT in reducing low-income preschoolers disruptive behaviors compared to children in an active control group as reported by the teachers. Child-centered play therapy was shown to reduce the disruptive behaviors with preschool children in a Head Start program. However, this was the only article found outlining CCPT as an effective intervention with preschoolers. It is apparent that more research needs to be conducted to establish CCPT as a developmentally appropriate intervention with preschool children.

Need for the Study

The research cited above clearly demonstrated that preschool children's externalizing behaviors affect their later social, emotional and academic development. The research also demonstrated that low-income children and males are harder to teach and more at risk for behavior problems. However, there was a lack of research examining

the effect of CCPT on low-income preschool males exhibiting externalizing behaviors. Research in this area is important for several reasons. First, and most important, the findings could provide counselors with information about an intervention that could alleviate current and future issues that male preschoolers face. Second, it could assist counselor educators in the training of new counseling students interested in working with young children. Third, it could provide information about the effectiveness of an intervention that is appropriate for preschool children who are in poverty.

Purpose

To address this need, this study proposed to assess the effect of child-centered play therapy on low-income male preschool externalizing behaviors as perceived by an independent observer during center time and group instructional time.

Research Questions

The following research questions addressed were:

1. What is the effect of CCPT on the externalizing behaviors of low-income preschool males who exhibit externalizing behaviors during instructional time?
2. What is the effect of CCPT on the externalizing behaviors of low-income preschool males who exhibit externalizing behaviors during center time?

Operational Definitions

Externalizing Behavior

Externalizing behaviors were defined as the externalizing subscale score on the Child Behavior Checklist/Caregiver-Teacher Report Form for Ages 1½ - 5 (C-TRF 1.5-5; Achenbach & Roscorla, 2001; See Appendix A). The externalizing subscale defined

externalizing behaviors as aggressive behavior and attention problems. There were 34 items and all 34 were be used. A sample of aggressive behaviors included defiance, destroying property, hitting other people, screaming, and overall angry mood. A sample of attention behaviors included inability to concentrate, clumsy, and wanders.

Child Centered Play Therapy

Child-centered play therapy was defined as the intervention, measured by the Play Therapy Skill Checklist (PTSC; Ray, 2011; See Appendix B). The reliability of CCPT was defined as the interventionist as having at least 90% CCPT responses on the PTSC rated by an outside observer/supervisor. These skills included non-verbal and verbal communication. Non-verbal communication included the way a therapist sits, the tone used, appearing interested in the child, relaxed with the child, the depth of the relationship, and the rate of responses. Verbal communication was the responses of the therapist and included the responses to play behaviors, responses to the child's feelings, returning responsibility responses, esteem building responses, limit setting, and facilitating the relationship.

Low Socio-economic Status

Low socio-economic status was defined by the United States Department of Agriculture, Food and Nutrition Service (https://www.fns.usda.gov/fr-032316) in 2017, as a child who qualified to receive free breakfast and lunch. According to the 2017 United States Department of Agriculture, Food and Nutrition Service (https://www.fns.usda.gov/fr-032316) family income requirements, a child to be eligible for free breakfast and lunch is based household size. This ranges between annual incomes

of $15,444 (roughly $1,268 a month) for a one-member household to an annual income of $53,157 (roughly $4,430 a month) for an eight-member household.

Assumptions

The assumptions made in this study were:

1. The teachers knew the children well enough to assess the children's externalizing behaviors.
2. All the children in the study were male.
3. All the children in the study demonstrated aggressive behaviors and/or hyperactivity in the classroom as indicated by the teachers' scores on the C-TRF 1.5-5.
4. The independent observers who conducted the assessment were trained on how to use the C-TRF 1.5-5.
5. The therapist reliably used the CCPT skills.

Delimitations

The factors the researcher controlled in this study were:

1. The researcher selected the preschool used for the study.
2. All students were from one classroom in the preschool.
3. The teacher rated all of the male children on the C-TRF 1.5-5. The male children with the highest scores on the C-TRF 1.5-5 were invited to participate in the study.
4. The observers, collecting the data rated all five males and did not know which child received the intervention.

Limitations

The factors beyond the researcher's control that may limit the generalizability of this study's findings were:

1. A convenience sample was be used. Because the children attended one preschool in a southeast urban area, the results may not be generalizable to children in other areas.
2. The single-case design had a small sample size. While predictions could be made, more research will need to be conducted to generalize results.

Summary

This chapter outlined issues preschoolers with externalizing behaviors face and the need for a developmentally appropriate intervention to effectively address these issues. It provided an overview of externalizing behaviors and how these behaviors affect students throughout their education and beyond if left unattended. An overview of CCPT was also addressed with elementary aged children. However, there seemed to be a lack of research on CCPT with preschool children exhibiting externalizing behaviors.

Organization of the Study

This dissertation includes five chapters. The first chapter proposes an argument for the study. It also gives operational definitions of the variables used in the study, including the background information on the significance of the dependent variable (externalizing behaviors) in preschool children's lives, an overview of the independent variable, CCPT; research questions; assumptions; limitations; and delimitations. In chapter two, a review of the literature is presented. This includes further information on

the independent and dependent variables, and how they impact preschool children. This includes the stress that teachers feel when a child is exhibiting externalizing behaviors in the classroom. This chapter also outlines the current evidence based practices that are not developmentally appropriate for preschoolers and the lack of research found on the effect of CCPT on preschoolers. Chapter three outlines the methodology used in the study. This includes the participants, setting and materials, the researcher, data collection procedures, data analysis, and experimental design that will be used. Chapter four presents the results, including information regarding Inter-observer Agreement (IOA), procedural reliability for CCPT, results for the dependent variable, externalizing behaviors, other results regarding the classroom dynamics, and social validity information gathered from the teacher. Finally, chapter five includes a discussion about the results, limitations, implications, and recommendations for future research.

CHAPTER II: REVIEW OF THE LITERATURE

The purpose of this study was to assess the effect of child-centered play therapy on male preschool externalizing behaviors as perceived by an independent observer during group instructional time and center time. This chapter contains a review of conceptual and empirical literature regarding this issue demonstrating the need for this research.

The chapter is comprised of six main sections. The first section provides an overview of mental health issues faced by children. The dependent variable, externalizing behaviors, is explored more fully in the second section. The dependent variable section includes the empirical research on the effects of externalizing behaviors on children, the effect of externalizing behaviors on the teacher-student relationship, including the influence of gender and family income in viewing externalizing behaviors. The third section discusses the responsibility of counselors in supporting preschool children with externalizing behaviors. The fourth section explores the intervention, child-centered play therapy (CCPT), which serves as the independent variable in this study. This section includes the theoretical bases of CCPT with children, the lack of research with preschoolers, and the relationship between CCPT and externalizing behaviors. The last section contains a summary of the literature pointing out the need for further research in this area with preschoolers.

Overview of Mental Health Issues Faced By Children

The mental health needs of children and their families have created a health crisis in the United States (Mellin, 2009, U. S. Department of Health and Human Services,

2000;). Over 20% of children and adolescents have experienced mental health problems (Committee on School Health, 2004), and in 2000 approximately one in five children received treatment for a diagnosable mental, emotional, or behavioral disorder (U.S. Department of Health and Human Services, 2000; Merikangas et al., 2010). Externalizing behaviors have contributed to many of these diagnoses. Externalizing behaviors are defined as behavior problems that negatively affect children's external environment, such as home, community, or school (Campbell, Shaw, & Gilliom, 2000; Eisenberg et al., 2001) and includes aggressive and hyperactive behaviors. Aggression and hyperactivity affects children of all ages, including preschoolers. It is common for preschoolers to be somewhat aggressive and/or hyperactive; however, persistent aggressiveness or hyperactivity can be a sign of something more serious.

Oppositional defiant disorder (ODD) is a diagnosis given to children who exhibit aggressiveness. According to the most recent edition of the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM; 2013) ODD is defined as:

> A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling. (p. 462)

Some of the symptoms in the description of ODD include losing temper, easily annoyed, often angry, arguing with authority figures and peers, refuses to comply with requests and/or rules, deliberately annoys others, and blames others for mistakes or

misbehavior. These behaviors and symptoms also must cause distress with others around them and must negatively impact them in an important area of functioning. The prevalence of ODD is around 3.3% and is more frequent in males than females (American Psychiatric Association, 2013). Symptoms of ODD can emerge as early as four or 5-years-old and can be a precursor for a conduct disorder if left untreated (U. S. Department of Health and Human Services, 1999).

Attention deficit/hyperactivity disorder (ADHD) is the diagnoses given to children who exhibit hyperactivity and inattention. According to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (2013), ADHD is defined as "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (p. 59). Some of the inattentive behaviors include distractibility, lack of attention, and lack of organization. The hyperactive-impulsive behaviors include fidgeting, leaving seat when not appropriate, running or climbing, unable to play quietly, acts like driven by a motor, talks excessively, blurts out, has difficulty waiting their turn, and often interrupts or intrudes on others. These symptoms must be present in two different settings and must interfere with functioning. Attention deficit/hyperactivity disorder is one of the most frequent diagnoses in childhood, affecting around 5% of children (American Psychiatric Association, 2013). Children diagnosed with ADHD tended to have behavior issues into adulthood that affected education levels, job status, and arrest reports (Barkley, Fischer, Smallish, & Fletcher, 2002).

Aggressive and hyperactive behaviors by children were shown to be a drain on mental health services and a menace to society (Committee on School Health, 2004). This is why it is imperative for these aggressive and hyperactive behaviors to be detected early by educators and mental health professionals. Once detected, a developmentally appropriate and culturally sensitive treatment modality needs to be implemented by a trained and culturally competent counselor. Child-centered play therapy has been shown to be a developmentally appropriate and culturally sensitive intervention that has assisted in reducing aggression and hyperactivity for children in school (Baggerly & Parker, 2005; Cochran, Cochran, Fuss, & Nordling, 2010; Garza & Bratton, 2005; Landreth, Ray, & Bratton, 2009; Ray, Schottelkorb, & Tsai, 2007).

Externalizing Behaviors

Aggressive and hyperactive behaviors have many negative effects on preschoolers. Several research articles described the lasting negative effects of aggressive and hyperactive behaviors. One such article described the impact of these behaviors on success in school entry (Denham, Bassett, Zinsser & Wyatt, 2014). Another such article explained that these behaviors begin as early as toddlerhood and had lasting affects into the early school years (Brennan, Shaw, Dishion, & Wilson, 2012). If left untreated, aggressive and hyperactive behaviors continued on into middle school (Moilanen, Shaw, & Maxwell, 2010) and drastically affected the adult years (Wilson & Marcotte, 1996).

Several research articles also indicated that aggressive and hyperactive behaviors affected the teacher-child relationship. The way teachers viewed children were based on the children's behaviors. When children exhibited aggressive and hyperactive behaviors,

this was found to cause teacher stress (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014), and created a negative student-teacher relationship (Pianta & Stuhlman, 2004). Teachers commonly viewed behaviors of children through the gender, SES, and ethnicity of the child (Bloom & Cohen, 2009; Hughes, Gleason, and Zhang, 2005; Silver, Measelle, Armstrong, & Essex, 2005). This was particularly true of the difference in the way teachers view African American males in comparison to females and other ethnicities (Allen, 2015; Milner, 2015). This section will further examine the empirical research related to the externalizing behaviors of children, the impact of externalizing behavior on the teacher-child relationship, and the relationship between the externalizing behaviors of males, poverty, and the perception of teachers.

Empirical Research Related to Externalizing Behaviors of Children

Preschool aggressive and hyperactive behaviors have a negative effect on success into school entry and academic success in elementary school. When preschool children exhibit these behaviors, it is believed, by parents and teachers, they are not ready to begin school. This is referred to as social-emotional learning (SEL). Denham, Bassett, Zinsserm and Wyatt (2014) define SEL as parents' and teachers' perceptions that children have the ability to follow rules, interact with peers and adults, and possess independence in the classroom. They believe these factors are important to academic success. Because SEL is essential for academic success, and aggressive and hyperactive behaviors negatively affect SEL, it is important for teachers and counselors to assess children at a young age and implement a developmentally appropriate intervention, like CCPT, to reduce aggressive and hyperactive behaviors.

Children with low SEL tend to have more externalizing behaviors, such as opposition to authority, aggression, hyperactivity, and lack the ability to pay attention. Research indicates that these behaviors began as early as toddlerhood and tended to continue if left untreated. Brennan, Shaw, Dishion, and Wilson (2012) examined the link between toddler-aged externalizing behaviors and academic achievement in a longitudinal study. Children and their families were recruited from the Women, Infants, and Children Nutrition Program (WIC) in three urban cities in Pennsylvania, Organ, and Virginia. Families with children who exhibited externalizing behaviors, from age 2 years and 0 months to 2 years 11 months were chosen. The parents completed assessments and the randomly assigned families received three sessions of The Family Check-Up intervention, based on motivational interview techniques. Several assessments, including the Child Behavior Checklist 1.5-5 and 6-18 (Achenbach & Rescorla, 2001), were used to examine demographics, language, behavior, and academic achievement. These assessments were administered at ages 2, 3, 4, 5, and 7.5 years. Results indicated that there was a negative correlation between ages two to 3-years aggression and age 7.5-years academic skills, albeit small. There was also a modest relationship between hyperactive/inattentive behaviors at ages two to 3-years and academic skills at age 7.5-years. However, the results from the multivariate path analysis, with child gender, child race/ethnicity, child language, and parent educational level as covariates, indicate that only aggression at ages two to 3-years had a relationship with age 7.5-years letter-word identification ($\beta = -0.136;\ \rho < 0.05$), and spelling ($\beta = -0.123;\ \rho < 0.05$). These results demonstrated the lasting and negative impact that hyperactive and aggressive

behaviors can have on children during the early years of school. Understanding how hyperactive and aggressive behaviors negatively impact children during the early years, reinforces the need for a developmentally appropriate intervention that can reduce aggressive and hyperactive behaviors in children as young as three.

Not only do externalizing behaviors, such as aggression and hyperactivity, affect the first few years of children's academic career, but the effects reach into the middle school years as well. Moilanen, Shaw, and Maxwell (2010) examined 291 at-risk boys who were beginning elementary school and their transition from elementary to middle school. This research is based on the adjustment erosion hypothesis. This hypothesis believes "initial externalizing or internalizing symptoms reduce later academic competence and increase future vulnerability to symptoms from other domains" (Moilanen, Shaw, and Maxwell, 2010, pp. 636). In other words, aggressive and hyperactive behaviors expressed in preschool limit children's opportunities for learning in the classroom and increases rejection from positive relationships with peers and teachers, thus affecting academic success. Parent quality, which included the parenting skills parents used, was assessed at age 2, the child's intelligence was assessed at age 5.5, and neighborhood quality, which included the safety and violence levels of the neighborhood, was assessed at ages 1.5, 2, 3.5, and 5 years. Parents and teachers completed several assessments, including the CBCL (Achenbach & Rescorla, 2001) and Teacher Report Form (TRF; Achenbach & Rescorla, 2001), at ages 6, 8, 10, 11, and 12 to assess externalizing behaviors, internalizing behaviors, and academic success. The results indicated that externalizing behaviors from ages 6 to 8 and from ages 8 to 10 were linked

to poorer academic competence in middle school; externalizing behaviors at ages 6 and 8 were associated with poorer academic competence at ages 8 and 10; poorer academic competence at ages 10 and 11 were associated with externalizing behaviors at ages 11 and 12; and high externalizing behaviors at school entry (age 6) and the transition to middle school (age 11) predicted higher internalizing behaviors, such as anxiety and withdrawal, at ages 8 and 12. This research indicated support for the adjustment erosion hypothesis with regards to externalizing behaviors in that higher externalizing behaviors were linked to poorer academic competence, even into middle school. There was also a link between the early neighborhood environment and externalizing behaviors at school entry.

While the adjustment erosion hypothesis was supported in Moilanen et al.'s (2010) study, it is important to take note these children came from low income families living in poorer neighborhoods. It is also important to take into account the affect the neighborhood environment played in determining externalizing behaviors. The neighborhood quality was assessed at ages 1.5, 2, 3.5, and 5 years, and it was linked to the externalizing behaviors of children at school age entry. This was age 6 in this study. The study suggested that children who had a more negative neighborhood environment might exhibit higher externalizing behaviors. It was thought that children in negative neighborhood environments were socialized to accept behaviors that were aggressive and hyperactive. It was also believed that children in these neighborhoods were taught values about academic behaviors that lead to the belief that academic success was not important. This speaks to the influence children's environment play on their behaviors in school.

This finding highlights the need for an intervention that is developmentally appropriate to work with preschool children who experience stressors from their environment. Child-centered play therapy assists in reducing emotional turmoil, thus reducing aggressive and hyperactive behaviors so they can learn to regulate their emotions and be successful in school.

Children learn the value of education from their parents and this affects the way they behave in school. The way that children behave affects teachers' reports, and teachers' reports are important in the way children move through school. Research indicates that teachers' reports on negative behaviors of kindergarten children had a negative impact on the trajectory of school completion. Vitaro, Tremblay, Brendgen, and Larose (2005) examined the effect of parental child-rearing attitudes and teacher-related characteristics on high school non-completion with 4,330 kindergarteners who exhibited disruptive behaviors (such as hyperactive and aggressive). Results from this study indicated that kindergarteners with teacher-reported high aggression were less likely to receive a high school diploma by age 20 than kindergarteners with low and average teacher-reported aggression. In this same study, the kindergarteners with teacher-reported average and high hyperactivity/inattentive were less likely to receive a high school diploma by age 20 than kindergarteners with low teacher-reported hyperactivity/inattentive behaviors. These results are disturbing and emphasize the importance of intervening with disruptive behavior before a child begins school.

Aggressive and hyperactive behaviors in early childhood not only have the potential to negatively affect children well into middle school and high school, but also

have the potential to have a negative affect into adulthood. It is suggested that this long-term effect is due to aggressive and hyperactive impeding social and emotional development. Wilson and Marcotte (1996) found that children diagnosed with ADHD and/or conduct disorder (CD) were more likely to have lower academic performance, social skills, emotional difficulties, and higher substance/alcohol abuse than the control group that had no childhood diagnosis. This study concluded that externalizing behaviors in early childhood had the potential to negatively affect not only the adolescent years, but well into the adult years, again highlighting the need for early and developmentally appropriate intervention, like CCPT, with preschool children.

Externalizing (aggressive and hyperactive) behaviors have a detrimental effect on children if left untreated. The results from the articles in this section outlined a timeline from toddlerhood to adulthood, and demonstrated this negative effect. However, early detection and intervention of externalizing behaviors can change the negative trajectory of children's academic success. Counselors have a responsibility to provide treatment that is developmentally appropriate and theoretically sound. Child-centered play therapy meets these criteria and has been shown to have an indirect effect on teacher-student relationships.

Externalizing Behaviors and the Teacher-Student Relationship

Teachers' perceptions of children are crucial and, for the most part, seem to be based on the children's behavior. Hyperactive and aggressive behaviors were found to be a source of contention as children began school and were correlated with many negative school outcomes (Campbell, Spieker, Burchinal, Poe, & The NICHED ECCRN, 2006).

Several research articles indicated that these behaviors resulted in increased teacher stress (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014), created a negative student-teacher relationship (Pianta & Stuhlman, 2004), and commonly resulted from the way a teacher viewed the gender and ethnicity of the child (Bloom & Cohen, 2009; Hughes, Gleason, and Zhang, 2005; Milner, 2015; Silver, Measelle, Armstrong, & Essex, 2005).

Preschoolers' aggression and hyperactivity raise teachers' stress and negatively affects the way teachers view the preschoolers who cause the stress. Research indicated that behaviors, such as aggression and hyperactivity, increased teacher's stress (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014), influenced how the teacher responded to children (Green, Beszterczey, Katzenstein, Park, & Goring, 2002; McComas, Johnson, & Symons, 2004), and changed teachers' view of the children's ability to learn (Rimm-Kaufman, Pianta, & Cox, 2000). Friedman-Krauss et al., (2014) examined preschool teachers' stress using multilevel modeling. The sample included 97 teaching staff from 35 classes of the Head Start and Early Head Start programs in Ohio. The Head Start (n = 30) programs served three and four year olds from low-income families, while the Early Head Start (n = 5) program served infants and toddlers from low-income families. The results indicated that there was a statistically significant relationship between teacher-reported behavior problems and the teachers' stress. Research also indicated that aggressive and hyperactive behaviors not only led to higher teacher stress but also suggested that teachers responded less frequently to children who exhibit these behaviors (Green, Beszterczey, Katzenstein, Park, & Goring, 2002; McComas, Johnson, & Symons, 2004). This may be due to teachers' perception that

children's ability to regulate emotions correlated with their teachability (Rimm-Kaufman, Pianta, & Cox, 2000). In other words, the more hyperactive and/or aggressive children were, the higher the teacher stress. This resulted in the teachers' reduced belief in the aggressive/hyperactive children ability to be taught. When teachers believe children cannot be taught, they respond less to them.

Preschoolers' problematic behavior not only leads to teacher stress, but research also has suggested that hyperactivity and aggression lead to a negative teacher-student relationship. Pianta and Stuhlman (2004) examined how students' behaviors affected teacher-student relationship. Four hundred and ninety children, their families, and their teachers were observed throughout preschool, kindergarten, and first grade. First grade teachers rated children's achievement more highly when there was less reported conflict in the relationship. In contrast, first grade teachers rated children's achievement lower when there was more reported conflict in the relationship. Both kindergarten and first grade teachers reported teacher-student relational conflict with children who exhibited high externalizing behaviors (hyperactivity and aggression) and low social competence. This study also found a significant relationship between preschool teachers' reports of social competence and first grade teacher's reports of social competence, indicating that the quality of the teacher-student relationship was stable throughout preschool, kindergarten, and first grade.

Not only do preschoolers with problematic behaviors increase teachers' stress, but they also are more susceptible to expulsion than elementary aged children. Gilliam (2005) examined expulsion rates in state prekindergarten systems, and found that

preschoolers had higher expulsion rates than that of elementary aged children. To begin with, he found a preschool expulsion rate of 27.4 children per 1,000 children enrolled in the Massachusetts preschool system. He then compared the expulsion rates of preschoolers to the expulsion rates of K-12 student in the Massachusetts area. He found the rate if expulsions for preschoolers were 34 times the rate of K-12 students. These state expulsion rates were also compared to national expulsion rates. He found that the national expulsion rate for preschoolers was more than 13 times the national expulsion rate of K-12 students. The teacher's level of job related stress was found to significantly contribute to the rate of expulsion.

The research has shown that aggressive and hyperactive behaviors have a negative effect on the way teachers view and respond to children (Green, Beszterczey, Katzenstein, Park, & Goring, 2002; McComas, Johnson, & Symons, 2004). This affects the quality of the teacher-student relationship, which has been shown to be stable throughout preschool, kindergarten, and first grade (Pianta & Stuhlman, 2004). Research also indicated that teachers' stress contributed to the high rate of preschool expulsion (Gilliam, 2005). Early interventions that are developmentally appropriate for preschool children could prove to be beneficial for young children by reducing externalizing behaviors, thus reducing teacher stress, thus reducing expulsion rates. This could promote the success of children throughout their academic career and into adulthood.

Externalizing Behaviors and Low-Income Preschool Males

Poverty has unfavorable effects on children's behaviors. In a review of the literature, Qi and Kaiser (2003) found preschool children from low-income families were

at a higher risk of behavior disturbances, such as aggression and hyperactivity, than the overall population. The review was comprised of 30 articles. The inclusion criteria included children from age 2-years to age 6-years, from a low socioeconomic status, with at least one behavior problem, based on either parent or teacher report. The most frequent assessments used were the Child Behavior Checklist (CBCL, Achenbach, 1991) and the TRF 1.5-5 (Achenbach, 2001).

Research also indicated family SES affects children's behaviors at school. Qi and Kaiser's (2003) review indicated teachers reported low-income children were more likely to experience high externalizing behaviors than those in the general population. Six studies examined the teacher reported externalizing behavior problems of preschoolers on the Teacher Report Form (TRF; Achenbach, 2001) in a Head Start program. The results indicated teachers reported 16% to 30% of these low-income children exhibited externalizing behaviors, many in the clinical or borderline range.

In this same study, parents reported males were more likely to demonstrate externalizing behaviors than girls, and this was even higher in low SES populations. The parents' report on the CBCL (Achenbach, 1991) indicated their belief that boys were more likely to exhibit externalizing behaviors than girls. Two studies reported that 21% to 25% of boys exhibited externalizing behaviors in the clinical range in contrast to 13% of girls. Of these 21% to 25%, around 75% of the boy also exhibited internalizing behaviors indicating a high level of anxiety in the children.

The findings in Qi and Kaiser's (2003) review also suggested certain factors were positively correlated with increased risks of behavior problems for low-income children.

These factors included parent characteristics (parent substance abuse, maternal depression, harsh discipline style, and absence of father), child characteristics (gender, social skills, cognitive ability, attachment status) and sociodemographic effect (poverty, family instability, exposure to violence, low maternal education level, and poor support). These findings suggested the need for early intervention to counteract these factors at home that correlate with externalizing behavior problems that affect success in school. Qi and Kaiser (2003) suggested interventions such as parent training and increasing the child's social skill would be helpful. The skills learned in CCPT are appropriate to assist parents in the skills necessary to counteract child stress and can also assist children in learning social skills.

Not only does poverty affect the behavior of children in the classroom, but the gender of children also affects the overall perception of behavior. Preschool males receive more severe consequences for hyperactive and aggressive behaviors than females. Gilliam (2005) surveyed 3,898 prekindergarten classrooms across 40 states and found that 6.67 out of 1000 preschoolers are expelled per year. The results indicated that male preschoolers were 4.5 times more likely to be expelled from preschool than females. Teachers reported that low-income children could be extremely stressful to teach because they were more likely to exhibit behavioral and academic problems (Zhai, Raver, & Li-Grining, 2011).When behaviors cause teachers stress and become unmanageable, the result is a damaged student-teacher relationship. Due to the perception that students from a low SES have higher externalizing behaviors and the high expulsion rates of these

children, it is important to consider interventions, like CCPT, that are culturally sensitive as well as developmentally appropriate.

Male students are more likely to experience conflict within the student-teacher relationship due to actual or perceived aggressive and/or hyperactive behaviors. Saft and Pianta (2001) examined the factors that influenced teacher-child relationship. They hypothesized that teachers would report more positive relationships with Caucasian children and with girls. A total of 197 teachers rated 840 children, with the mean age of 4-years, 7-months, using the Student-Teacher Relationship Scale (STRS; Pianta, 1993). It was suggested that the gender and ethnicity of children magnified this conflict because of the different expectations teachers had for different groups. In other studies, teachers reported that boys exhibited higher generalized behavior disturbance (Fergusson & Horwood, 1987) and saw girls as more prosocial, thus receiving more teacher support than boys (Hughes, Gleason, Zhang, 2005; Junttila, Voeten, Kaukiainen, & Vauras, 2006). Another study indicated that teachers' reported more hyperactivity in males than in females (Bloom & Cohen, 2009). Perhaps these differences in teachers' perceptions is one reason males are twice as likely be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) as females (Bloom & Cohen, 2009). Understanding the differences in teachers' perceptions of males further strengthens the need for a developmentally appropriate intervention for preschool males.

Teachers may have a different view of boys' hyperactive behaviors because they also exhibit the behaviors that resemble ODD whereas girls with hyperactivity typically do not exhibit ODD behaviors. Symptoms of ADHD and ODD co-occurred at a rate of

30% to 50% among children (Biederman et al., 1991 as cited in Bunford, Evans, & Wymbs, 2015); however, symptoms of ODD look different in children with ADHD. Bunford, Evans, & Wymbs (2015) examined emotional dysregulation (ED) in children with ADHD in a review of the literature. Emotional dysregulation (ED) was defined as "an individual's inability to exercise any or all aspects of the modulatory processes involved in emotion regulation, to such a degree that the inability results in the individual functioning meaningfully below his or her baseline" (pp. 188). The authors suggested that some children exhibited symptoms of ED instead of ODD or other disorders that were commonly comorbid with ADHD. While ED expressed differently with other disorders, anger, defiance, and symptoms of ODD were exhibited in ADHD. ED was also thought to be associated with risky behavior and social impairment. The literature indicated ED was more likely to be experienced by boys with externalizing behaviors than girls, further strengthening the necessity for a developmentally appropriate intervention for aggressive and hyperactive behaviors for preschool males.

It seems logical that aggressive children will lose friends and experience isolation from peers. However, several studies have shown that while this is true for some children, it is not for others. Ahn and Rodkin (2014) examined this idea with 778 fourth and fifth graders. Assessments were taken in the fall (time 1) and in the spring (time 2) to study aspects of aggression. In one assessment, the students were asked questions about aggressive tendencies. These included categories like "make fun of, say mean things, and start fights" (pp. 1147). The results indicated that over time, aggression had a negative effect on the social status of boys in the classroom when teachers were aware of the

friendships of the children, whereas there were no effects on girls' social status. This speaks to the differences in the way aggression is viewed by peers and the impact teachers' perceptions of aggression influenced the way aggression was viewed by peers. Perhaps the societal expectations of girls played a roll in these results. Girls are not normally thought of as physically aggressive, so their behaviors were not viewed as aggressive as boys' behaviors. These results reinforce the need for interventions that can assist in reducing aggressive behaviors in males.

Knowing that a vulnerable group has more stressors and more negative perceptions than another group, it is the responsibility of counselors to step in early to assist these children with their social and emotional development. Child-centered play therapy has been shown to help children with social and emotional development, so the purpose of this study is to address these issues by exploring how CCPT affects externalizing behaviors among preschool males.

Responsibility of Counselors

Counselors have a responsibility to advocate on behalf of their client (Chang, Crethar, & Ratts, 2010). Children are a vulnerable group that is dependent on a system of adults, including parents and teachers, to meet their needs; however, this system of adults is not always a support system for the needs of children. This can be seen most within the school where much time has been spent on the cognitive development of children with little time spent on social development and emotional school readiness (U.S. Public Health and Human Services, 2000). It is imperative, as counselors, to strive to remove the emotional and social barriers to learning by catching and treating these barriers early on.

This is especially true for children who are more susceptible to emotional and social barriers. Child-centered play therapy is a therapeutic intervention that meets the developmental and emotional needs of children, so it is important to consider CCPT as a viable intervention for preschool children.

Play Therapy

Working with children in therapy is very different than working with adults. Counselors who work with young children must consider certain development issues, like the limited language skills, the cognitive processing ability, and the therapeutic alliance. Younger children require more effort in considering these developmental issues. Play therapy is a developmentally appropriate theoretical modality that addresses these development issues when working with children. The Association for Play Therapy (APT) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, Board of Directors, 1997, p.14). Therapists, who work with young children, tend to use play therapy because play is the natural language of children (Landreth, 2012); fantasy play is natural for children who are between three to 7-years old (Piaget, 1962); and preschool children form a therapeutic alliance better through an enjoyable activity such as play (Landreth, 2012; Rogers, 1942).

One issue that must be considered when working with preschool children is their limited ability for verbal communication. Language is one of the differences in working with preschool children and adults. Many preschool children are not verbal so it is

difficult for them to express thoughts and feelings through words. Landreth (2012) stated that play is the natural language of children and toys are their words, so children internally make sense of the world around them through play. One way this is accomplished is through abreaction. Freud created the term abreaction in the 1880's but it was not a concept he published about until 1920 (Freud, 1920; 1950). It refers to a healing process where children repeatedly played out events for the purpose of mastering the event. Children use abreaction to work through past traumatic events much like adults use words to tell a story over and over again. An example of abreaction was found with hurricane survivors. Saylor, Swenson, and Powell (1992) found that abreaction facilitated children's healing after Hurricane Hugo hit North and South Carolina in 1989. Parents reported that their children played out the hurricane over and over with any object they could find, including food. Because of the inability to verbalize feelings and thoughts, it is important for counselors to allow a child to play out events through pretend play for healing.

Another issue that must be taken into consideration, when working with preschool children, is the cognitive development of the client. Preschool children naturally engage in play that is not bound by reality. Because of this natural desire, it seems obvious that therapy with children should include elements of fantasy play. Play therapy allows counselors to meet children at an appropriate development stage where they can engage in fantasy play. According to Piaget (1962) preschool children operate on the preoperational stage. In this stage, Piaget believed that children use magical thinking to explain events they do not understand. For example, a child may think he/she caused an

earthquake when he/she stomped his/her foot because the events happened at the same time. Landreth (2012) believes that play is symbolic. Children, in the preoperational stage, work within this symbolic world through the use of play (Landreth, 2012; Piaget, 1962). Wilson & Ryan (2005) explain that the symbolic play allows children to freely play out their experiences without the restraint of the physical world. When working with children, it is important to use an intervention, like CCPT, that promotes pretend and fantasy play.

The importance of the therapeutic alliance is the last issue that must be taken into consideration when working with preschool children. Play therapy allows children to build a strong therapeutic alliance with counselors in an enjoyable and developmentally appropriate way. Preschool children may be resistant to adults they do not know or trust. So it is important to build this strong alliance to counteract this resistance. Rogers (1942) believed an empathetic relationship is the conduit for change in any client's life. Landreth (2012) reiterated the importance of a therapeutic alliance as the main change agent with children. Elliot, Bohart, Watson, and Greenberg (2011) supported the belief in the importance of a therapeutic alliance in a study that found the relationship between empathy and outcome in therapy had a medium effect size. In other words, clients who felt understood by their therapists tended to have better outcomes. Because of the significance of the relationship in play therapy, it is important for counselors to choose a therapeutic modality that focuses on the relationship. Child-centered play therapy is a type of therapy that does just this; however, many counselors use parent training and directive interventions with preschoolers.

Evidence-Based Practice

According to a past Surgeon General's report in 1999, regarding child mental health, the major types of psychotherapy for children included supportive, psychodynamic, cognitive-behavioral, interpersonal, and family systemic interventions (U. S. Department of Health and Human Services, 1999). Presently, behavior management therapies and parent training are still considered well-established evidenced based treatments for aggression and hyperactivity in children (Society of Clinical Child and Adolescent Psychology, Committee on Evidence-Based Practice, & Network on Youth Mental Health, 2016). However, the U. S. Department of Health and Human Services report from 1999 admitted that these therapies were created for adults and modified. They were only considered effective because children had greater improvements with treatment when compared to no treatment.

Both reports recommended evidence-based behavioral treatments for children with externalizing behaviors (Society of Clinical Child and Adolescent Psychology, Committee on Evidence-Based Practice, & Network on Youth Mental Health, 2016; U. S. Department of Health and Human Services, 1999). The American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents (2008) defined Evidenced-Based Treatment (EBT), Evidence-Based Practice (EBP), and explained the criteria for both. First, EBT referred to "either intervention or prevention programs for which there is a strong scientific evidence base" (pp. 20). Evidence-Based Treatments were created so that children would receive the best care available with trained clinicians. This care is received in an Evidence-Based Practice (EBP). The 2008

task force then explained that an EBP "is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (pp. 5). The 2008 Task Force adopted this definition from the 2006 Presidential Task Force on Evidence-Based Practice of the American Psychological Association. The main requirement for a practitioner to have an evidenced based clinical practice was empirical support, based on research, indicating the effectiveness for the interventions used.

At this point, behavioral interventions are the main treatments considered for an EBP for children with externalizing behaviors. Behavioral interventions include parent and teacher training in managing the symptoms of ADHD. However, in the 1999 report, it was noted that the behavioral interventions were not deemed helpful for the core issues of inattention, hyperactivity, or impulsivity. With regards to ODD, the diagnosis for aggression in young children, the recommended treatment was multi-systemic therapy (Henggeler, Melton, & Smith, 1992), which included a home-based treatment focusing on parent/family training and support to assist in changing the child's behavior. Other programs include the Incredible Years (Webster-Stratton & Hammond, 1997), which focuses on teaching parents and teachers' skills to change children's behavior; and different school based programs such as the Anger Coping Program (Lochman, 1992). Conversely, all these mentioned programs, with the exception of the Incredible Years program, are for older children over the age of eight and have not been fully examined with females, ethnic minorities, and preschool aged children.

Bunford, Evans, and Wymbs (2015) reported that behavior interventions do not seem to reduce ED and encourage practitioners to place a focus on interventions that

target emotional regulation. In contrast to behavioral interventions, CCPT has been found to be an effective intervention for children who exhibit externalizing behaviors while also addressing the ED of children (i.e., Blanco & Ray, 2011; Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2014; Ray, Blanco, Sullivan, & Holliman, 2009; Ray, Schottelkorb, & Tsai, 2007; Schottelkorb, & Ray, 2009) and is now considered an evidenced-based treatment. Young children could benefit from adults addressing externalizing behaviors by providing interventions as early as two years old (Brennan, Shaw, Dishion, & Wilson, 2012).

Empirical Research: Play Therapy and Preschoolers

Research indicates that CCPT is an EBT and effective intervention with young children under the age of seven (Lin and Bratton, 2014). However, after a review of the literature, it is apparent that research is lacking with preschoolers and CCPT and only one specific CCPT study with preschoolers was found (Bratton et al., 2013). Due to this fact, this section will examine current trends in play therapy, other than CCPT, with preschool children.

Play therapy, in general has been shown to be effective with preschool children; however, most of the research has centered on family therapy that was directive and taught parents skills to bring the child's behaviors under control. For example, Yu, Roberts, Shen, and Wong (2015) found that behavioral family therapy (BFT) reduced disruptive behavior scores on the Aggressive Behavior Subscale of the Child Behavior Checklist (CBCL; Achenbach, 1991). The sample consisted of nineteen children ages 2 years to 6 years (M age = 4.3 years; SD = 0.9 years) in Shanghai, China who exhibited

disruptive behaviors. The children were mostly only children (95%) and male (79%). The BFT used the Helping the Noncompliant Child (HNC; McMahon & Forehand, 2003) as the intervention in this study. The HNC was an evidenced based intervention that was adapted to five 1 – 1.5 hour individual parent sessions that taught parenting skills and the use of time out as a consequence. The results indicated that the primary caregivers' perceptions of the child's problematic behavior were significantly reduced; the caregivers were less controlling and more responsive during playtime; and caregivers were very satisfied with the parent training. This study suggests that directive behavioral parent training is effective; however, this study only included well-educated, middle class families. The results might be different in lower socioeconomic status families.

Combined directive and nondirective approaches to family therapy, where parents are trained to respond to behaviors, are also used to treat preschoolers. Graziano et al. (2015) found that an intensive form of parent-child interaction therapy (PCIT) was effective for reducing externalizing behaviors in preschool children. There were 11 children in this study with the mean age of 5. Most of the children were Hispanic (73%) and male (91%). The intervention included two phases: Child Directed Interaction (CDI) and Parent-Directed Interaction (PDI). The skills in the first phase, CDI, looked very much like CCPT where the parent allowed the child to lead, responded to the play behavior, reflected feelings, and avoided questions, commands, and negative statements. The second phase, PDI was more behavioral and parents were taught to set limits, and follow through on consequences. Parents attended ten 90-minute sessions where the first five days were for teaching and the second five days were for performing the skills with

the child. Results indicated that parenting skills increased, parenting stress decreased, and externalizing behaviors decreased in children. While teaching parenting skills is important, this study also included relationship-building skills that looked very much like the CCPT skills taught to parents in child-parent relationship training (CPRT). The overall success of this intervention seemed to be given to the directive training in reducing behavior; however, it is important that a change in the parent-child relationship may have actually met the child's needs, thus, reducing the behaviors. These same changes are the focus of CCPT and also occur in CPRT. Child-parent relationship training teaches parents the same skills used in CCPT and credits the parent-child relationship as the conduit for change.

Tarver, Daley and Sayal (2014) are skeptical of the effectiveness of parent training. In a review of the literature, Tarver et al. believed that parental bias played a role in parent-reports when parents are involved in the intervention, skewing the results to more positive outcome. At the same time, this study reported that parent training could be effective in reducing chaos and parental stress, thus reducing the children's externalizing behaviors. While it is recommended that more research be done to assess the effectiveness of parent training, CPRT has demonstrated significant effects for many different families and situations and according to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices, both CPRT and CCPT are now considered an EBT (http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1225#show4).

Mindfulness is another form of therapy that was found to be effective with preschool children. Razza, Bergen-Cico, and Raymond (2015) found yoga to be effective on self-regulation in preschool children ages 3 to five (M = 51.1 months, SD = 3.8 months, range 46 – 57 months). There were 29 preschool children in this study (11 girls and 18 boys) who were placed in two groups: 16 in the intervention group, and 13 in the control group. Parents were well educated with 60% having a Masters or professional degree. The preschool classroom determined the groups, so they were not randomly assigned. The preschool teacher for the intervention group was trained and implemented a modified version of the Yoga Kids (Wening, 2003) curriculum for 25 weeks in the classroom. The yoga techniques were incorporated into the curriculum and implemented throughout the day. The techniques included deep breathing, animal poses (e.g., downward dog), and nature poses (e.g., mountain pose). The results indicated that the intervention group demonstrated significant improvements in inhibitory control over time, self-regulation improved for the children who had lower levels of self-regulation initially, and the intervention group maintained levels of focused attention, whereas the control group declined in focus attention. While these results are promising and suggest mindful yoga is effective, this intervention was conducted throughout the day in the classroom and could be time consuming for the teacher, and not all teachers may be willing to implement this throughout the day in their classrooms. So it is important to consider that not all children will have access to this type of intervention.

Summary

This review of the literature indicates that there are not many studies that examine play therapy specifically with preschoolers. Even in the three studies examined in this section, some of the age ranges were into kindergarten. Parent training was shown to be effective in two of the studies (Graziano et al., 2015; Yu et al., 2015) however; the sample size was small, making it difficult to generalize the results. In Graziano et al. (2015) study, parents were taught skills that looked like CCPT skills. These skills most likely strengthened the parent-child relationship, thus reducing the behaviors. In Yu et al.'s (2015) study, the primary focus was on behavior change and parents were taught skills to help the children comply with parents' directions. While parents like to see behavior change, there is normally a reason for the disruptive behavior. Many interventions for preschoolers, like PCIT, believe that as behaviors improve, the parent-child relationship improves. However CCPT believes the relationship is the conduit of change (Landreth, 2012) and young children cannot verbalize emotional duress, so they act out instead. So from this perspective, teaching a child to comply may work for the parent, but may not meet the emotional needs of the child. Child-centered play therapy, on the other hand assists with the emotional duress the child is feeling, thus reducing the unwanted behaviors.

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is a developmentally appropriate therapeutic modality used to work with children that takes into account language barriers, includes fantasy play, and focuses on the relationship between counselors and children. A major

principle of CCPT is that children are capable of growth and have the ability to take the therapy to where he/she needs it to go (Landreth, 2012). Landreth's concepts of CCPT are grounded in Rogers' (1942) person-centered philosophy and Axline's (1947) eight basic principles. Rogers thought that all people, regardless of age, have the capacity for self-actualization and positive self-growth. He believed the empathetic relationship was the conduit for change within the therapeutic relationship. Axline built on Rogers' person-centered (or client-centered) philosophy by applying non-directive play therapy as a viable treatment modality for children using her eight basic principles. These principles centered on the relationship, empathy, acceptance of the children where they are, and belief in the children's ability to change. Her work paved the way for Clark Moustakas (1953), Louise Guerney (2001), and Garry Landreth (2012) to further develop CCPT.

More current research indicated that CCPT is a therapy that is responsive to the needs of children (Bratton, 2010), respects the diversity of children (Baggerly & Parker, 2005; Garza & Bratton, 2005), is the most popular approach to play therapy in the United States (Lambert et al., 2005), is a beneficial therapy for children who exhibit problematic behaviors (Cochran, Cochran, Fuss, & Nordling, 2010), and according to SAMHSA National Registry of Evidence-based Programs and Practices, CCPT is now considered an EBT (http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1225#show4). While CCPT has been shown to be effective with elementary school children, after a review of the literature, only one study was found that examined the effect of CCPT on preschool children (Bratton et al., 2013) There seems to be a gap in the literature concerning

preschool children, indicating that the effect of CCPT on preschool children merits attention.

Empirical Research: Play Therapy with Children

Due to the limited research that includes CCPT and preschool children, this section will examine the overall effectiveness of CCPT with kindergarten and school-aged children. Child-centered play therapy has been shown to be an effective and culturally sensitive modality of therapy for children. The effectiveness of play therapy, nondirective play therapy, and CCPT was demonstrated throughout the literature in four meta-analyses. This included meta-analyses that examined play therapy in general (LeBlanc & Ritchie, 2001), compared direct theoretical modalities to non-direct modalities (Bratton, Ray, Rhine, & Jones, 2005), examined the effectiveness of CCPT in the school setting (Ray, Armstrong, Balkin, & Jayne, 2015), and examined the effectiveness of CCPT in general (Lin & Bratton, 2014). The effectiveness of CCPT with different cultures has also been demonstrated throughout the literature. These include articles that examined the effectiveness of CCPT with regards to self-concept where the majority of the sample was African American children (Post, 1999), the effectiveness of CCPT with African American boys (Baggerly & Parker, 2005), and the effectiveness of CCPT compared to another intervention with Hispanic children (Garza & Bratton, 2005). The effectiveness of CCPT with academic achievement has also been demonstrated throughout the literature. This includes research that spoke to the importance of reducing emotional turmoil for academic achievement (Axline, 1949), and the effect of CCPT on academic achievement (Blanco & Ray, 2011).

A relationship, like the relationship in CCPT, is a key factor in the outcome of therapy with children. LeBlanc and Ritchie (2001) conducted a meta-analysis, including 42 research studies, examining the effectiveness of play therapy (directive and nondirective), the effectiveness based on therapeutic modality, and the effectiveness based on other factors, such as length of treatment, age of child, etc. The mean age of children in this study was 7.9-years and the results demonstrated a medium to large effect size (0.66; $p < 0.001$), according to Cohen's (1988) effect size interpretation. This suggested that play therapy was an overall effective treatment when working with children. This study also indicated that therapies involving parent-child relationship were most effective. This included two therapies where the parents were trained to be the therapist. The two therapies included in this study were filial therapy, focusing on training parents to use CCPT with their children, and parent-child interaction therapy, which is a behaviorally based modality of play therapy. The results also suggested that the interactions between the parents and children were related to the children's outcomes. In other words, the relationship between the parents and the children was responsible for the positive change. This study also indicated that age or gender was not a significant factor in determining the therapeutic outcome. While this meta-analysis focused on both directive and non-directive play therapy, the results demonstrated the importance of the relationship in the children's therapeutic outcome. The study also suggested that there was no particular gender or age of children that benefited more from play therapy, indicating that all children can experience the benefits of play therapy.

While many therapists use directive approaches of play therapy, research indicates that nondirective was a more effective theoretical modality. Like LeBlanc and Ritchie (2001), Bratton, Ray, Rhine, and Jones (2005) also examined the efficacy of play therapy in another meta-analysis. This meta-analysis included 93 research studies on various approaches to play therapy. The large effect size (0.80) reported indicated that play therapy was an effective treatment. This effect size was higher than LeBlanc and Ritchie's (2001) effect size of 0.66, however this study included 53 more studies than LeBlanc and Ritchie's (2001) study, suggesting it was a more complete review of play therapy. Bratton et al's. (2005) meta-analysis also separated and compared directive and nondirective play therapy modalities. The results suggested that nondirective approaches (such as CCPT) reported a significantly higher effect size than directive approaches. Like LeBlanc and Ritchie's meta-analysis, Bratton et al.'s meta-analysis indicated that age and gender was not a significant factor in determining the therapeutic outcome, indicating that all children experienced benefits from play therapy. Regarding age, the mean age in the studies was 7.0 years. It was also reported that the majority of the studies reporting results for children 10 years and older included children who were developmentally delayed. Taking this into consideration, the mean developmental age may need to be adjusted to a younger age. While this meta-analysis did not focus primarily on CCPT, it did suggest that nondirective play therapy modalities, like CCPT, are more effective than directive play therapy modalities. Understanding the effectiveness of nondirective play therapy modalities gives validity to CCPT.

Child-centered play therapy is also effective for school-aged children when conducted within the elementary school setting. Ray, Armstrong, Balkin, and Jayne (2015) examined the effectiveness of CCPT within the school setting by conducting a meta-analysis with 23 studies. In this study, they hoped to provide further evidence that CCPT was an effective therapeutic modality with children and outline best practices for a school setting. The results indicated that CCPT was an effective form of therapy for elementary school aged children and it was a viable therapeutic modality to be used in schools. Two of the dependent variables in this study, teacher-child relationship and externalizing behaviors, relate to the current research. Social skills, attitude toward school, and teacher-child relationship were grouped together as a dependent variable and consisted of 4 studies. The results indicated a small to medium effect (d = .38) for children who received CCPT. Seven studies included externalizing behaviors as a dependent variable. The results demonstrated a small to medium effect (d = .34) for children with externalizing behaviors who received CCPT. These results are important to the current research for several reasons. First, the current study will build upon the results that indicated CCPT was viable therapeutic modality to be used in elementary schools by conducting the CCPT sessions in the children's school. The difference is that the current study will be conducted in preschool instead of elementary school to fill the gaps in the literature on CCPT and preschoolers. Second, like Ray et al.'s (2015) meta-analysis, the current study will speak to the teacher-child relationship. Third, and most importantly, to the current research, Ray et al (2015) found CCPT to be effective with externalizing

behaviors of elementary-aged children. The current research will build upon this research by examining CCPT with the externalizing behaviors of preschool children.

Child-centered play therapy is effective for all children, but it is also important to understand that it is effective and developmentally appropriate for preschool children. Lin and Bratton (2014) conducted a meta-analysis with 52 research studies to determine the effectiveness of CCPT. The overall average age of the children in this meta-analysis was 6.7-years, which is similar to the reported age of 7.0-years in Bratton et al.'s (2005) study and the reported age of 7.8-years in LeBlanc and Ritchie's (2001) study. A moderate effect size (.47; $p < 0.001$) was found indicating that CCPT was more effective than no treatment and alternative treatments. This study also considered the age of the child as a factor, and separated the studies into two age categories. This included 42 studies with the mean age of 7-years or younger and 10 studies with the mean age of 8-years and older. The 42 studies with children who were 7-years or younger had an effect size (.53) that was statistically significantly higher than the effect size (.21) from the 10 studies with children 8-years and older. Unlike Bratton et al.'s (2005) study and LeBlanc and Ritchie's (2001) study, age was considered a factor in intervention outcomes. Regarding age, this study indicated that CCPT is more beneficial for children younger than 7. While this result needs to be interpreted with caution, because of the low number of studies for older children, it still speaks to the fact that CCPT is a developmentally appropriate intervention and beneficial for children under 7-years of age. This meta-analysis also considered ethnicity. There were limited numbers of ethnic diversity in the 52 studies with over 60% of the children reported as Caucasian. Non-Caucasian children were

grouped into one category, which included African American, Latino/Hispanic, Asian/Asian American, and other ethnic groups. However, the average non-Caucasian effect size (.76) was statistically significantly higher than the average Caucasian effect size (.33). This result suggested that CCPT is more beneficial for non-Caucasian children. While the studies limited number of children from an ethnic minority must be considered, this result suggests that CCPT is culturally responsive to the needs of diverse populations. While the current study does not take ethnicity into consideration, it is conducted within a diverse, and low-income preschool where all the children receive free breakfast and lunch. The majority of these children, reported as ethnic minorities, are also from a low SES. These results are important to the current research because it speaks to the fact that CCPT is an effective early intervention for young children in poverty. The ages of children in this current study were 3-years of age and living in poverty.

Child-centered play therapy is effective for children in poverty. One study used in Lin and Bratton's (2014) meta-analysis demonstrated the effectiveness with this population. Post's (1999) research study included 168 at risk fourth, fifth, and sixth grade children at a Title I school, who were considered high risk. Out of these 168 children, 136 were African American and 98 were male. The results indicated that CCPT was shown to be effective with at risk fourth and fifth grade students in maintaining internal locus of control and self-esteem scores as reported by the students. In another study that focused on African American males, elementary school aged African American males demonstrated a statistical significant increase in their self-concept, attention and helpfulness in the classroom after receiving CCPT (Baggerly & Parker, 2005). In a

different research study, the results indicated that CCPT was also helpful for Hispanic children. Hispanic elementary school-aged students had a significant reduction in externalizing behaviors after 15 sessions of CCPT when compared to a curriculum-based group intervention (Garza & Bratton, 2005). These studies are significant to the current research because they not only demonstrate cultural sensitivity to ethnic minorities, but they also demonstrate sensitivity to the needs of children in poverty.

When children are in emotional turmoil, they cannot be expected to be productive students (Axline, 1947). Axline (1949) studied the relationship between CCPT and elementary aged children's academic achievement. Her research indicated that by assisting a child in removing the emotional and social barriers to learning through CCPT, children demonstrated increased academic achievement. Blanco and Ray (2011) built on Axline's (1949) findings by also examining the effect of CCPT on academic achievement. Blanco and Ray found that CCPT was significantly beneficial for first grade children who were at risk of academic failure. Results from this study indicated that the children who received CCPT scored significantly higher on the Early Achievement Composite of the Young Children's Achievement Test (YCAT; Hresko, Peak, Herron, & Bridges, 2000) than the children who did not receive CCPT. The play therapy group in this study had a 7.28-point increase in their mean scores of the YCAT whereas the control group only had a 3 point increase. These findings speak to the effect that CCPT has on academic achievement.

Child-Centered Play Therapy and Children's Externalizing Behavior

This review of the literature has already established CCPT to be a developmentally appropriate intervention that works well with children from majority and minority ethnicities and children in poverty. This section will establish CCPT as an effective treatment with children who are exhibiting aggressive and/or hyperactive behaviors. Because there are not many current studies that demonstrate this with preschoolers, this section will examine the only article found that examined CCPT and preschoolers with disruptive behaviors (Bratton et al., 2013), and will then address the effect CCPT has on kindergarten and elementary aged children with aggressive and hyperactive behaviors.

Child-centered play therapy is considered effective in reducing preschool children's aggressive behaviors when compared to an active control group, such as a reading-mentoring program. Bratton et al. (2013) conducted a study that examined the effectiveness of CCPT in reducing preschool disruptive behaviors compared to children in an active control group as reported by the teachers. The active control group consisted of a reading mentor (RM) group. Participants were in a Head Start program and were considered low income. There were 54 participants, 27 in the experimental group and 27 in the RM group, consisting of 42% African American preschoolers, 39% Hispanic preschoolers, and two thirds of the participants were male. The externalizing subscale of the C-TRF (Achenbach & Rescorla, 2001) was used to measure the children's disruptive behaviors. Both the CCPT intervention group and RM control group received an average of 20 sessions, 30 minutes, twice a week, and teachers did not know which children were

in the CCPT or RM group. The children's behaviors were assessed pre-intervention, mid-intervention, and post intervention. The results indicated statistically significant interaction effect of time (pretest, midtest, posttest) by group membership (experimental, active control); [Wilks' λ = 65, F (2, 51) = 13.28, p < .001 ($\eta \frac{2}{p} = 0.34; observed\ power = 0.99$)], suggesting that the experimental group demonstrated a statistically significant decrease overtime in disruptive behavior when compared to the control group. The effect size ($\eta \frac{2}{p} = 0.34$) indicated that CCPT had a large treatment effect on the children's disruptive behaviors when compared to the control group. Post hoc analyses were also conducted on the C-TRF syndrome scores of aggression and hyperactivity. Results demonstrated a statistically significant decrease overtime in both aggressive and hyperactive behaviors when compared to the control group, and CCPT demonstrated a large treatment effect on the children's disruptive behaviors when compared to the control group. These results suggest CCPT is an effective intervention for low-income preschool children with aggressive and hyperactive behaviors. These findings are important to the current research because they demonstrate the effectiveness of CCPT with preschool children. The current research study will build on this research by focusing on low-income, male preschoolers. The methodology of this research is also different than the current research. Bratton et al.'s (2013) research tracked the aggressive and hyperactive behaviors three times (pre-, mid-, and post-) and the current research used a single case study design and tracked the children's aggressive and hyperactive behaviors several twice a week throughout the study to determine the effect of CCPT on the classroom dynamics.

Like most evidenced based interventions, CCPT is also considered to be effective in reducing aggression when compared to no treatment. Ray, Blanco, Sullivan, and Holliman (2009) conducted a study with 41 elementary aged children who exhibited aggressive behaviors. This study included 32 boys and 10 girls from two Title 1 schools where the majority of the children were considered economically disadvantaged. Nineteen children were assigned to the CCPT group (15 males, 4 females, 10 children from a minority status) and 22 children were assigned to the waitlist group (16 males and 6 females). The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001), CBCL/1.5-5 (Achenbach & Rescorla, 2001) and the Teacher Report Form (TRF; Achenbach & Rescorla, 2001) were used to rate the students aggression levels pre and post intervention. The intervention group received 14 thirty-minute sessions of CCPT over 7 weeks. While parents did not report a significant difference in pre and post aggression scores, teachers reported a significant difference, indicating that CCPT was effective in reducing aggressive behaviors. The results suggest that teachers reported that CCPT reduced the aggressive behaviors in a low socioeconomic school with the intervention group. This speaks to the effectiveness of CCPT in reducing behaviors and changing the perceptions of teachers.

Child-centered play therapy is considered effective in reducing aggressive behaviors when compared to no treatment; however, CCPT is also considered effective in reducing aggressive behaviors when compared to other evidenced based interventions as well. The effectiveness of CCPT in reducing aggressive behaviors was demonstrated when compared to an evidenced based violence prevention guidance program within a

school setting. Schumann (2004) compared 20 children who participated in CCPT with 17 children who participated in a nationally recognized evidenced based guidance program. Both groups showed statistically significant reductions in aggressive behaviors over time, indicating that CCPT is equally as effective as evidenced based interventions. Qualitative data was also taken from the parents and the teachers in this study. Ten parents reported behavior improvements among the children in the CCPT group compared to the five parents who reported behavior improvements among the guidance group. Six teachers reported behavior improvements among the children in the CCPT group compared to the one teacher who reported behavior improvements among the guidance group. It is also important to recognize that no parents reported an increase in behavioral problems among the children in the CCPT group, whereas one parent reported an increase in behavior problems among the guidance group. Also, only one teacher reported an increase in behavioral problems among the children in the CCPT group, whereas two teachers reported an increase in behavior problems among the guidance group. The qualitative reports demonstrate clinical significance for the effectiveness of CCPT over an evidenced based guidance program. These results are important because they demonstrate the effectiveness of CCPT over, or equal to, an evidenced based guidance program in reducing aggressive behaviors within the school setting. This is important to the current study because it validates CCPT within the school setting and regards CCPT as an equal to or better intervention than other established evidenced based interventions.

Child-centered play therapy is also shown to be an effective and long-term intervention in the reduction of aggressive behaviors with males in poverty. A case study indicated that CCPT was an effective intervention in reducing the aggressive behaviors of two kindergarten boys in a Title I school (Cochran, Cochran, Cholette, & Nordling, 2011). Sessions were conducted for 30 minutes, twice a week. One child received 28 sessions and the other child received 10 (due to the teacher requiring him to stay in the classroom to make up work once his aggressive behaviors decreased). Data was collected using the Teacher Report Form (TRF; Achenbach & Rescorla, 2001) of the Child Behavior Checklist and indicated that the boys' aggressive behaviors were reduced. The boys tested limits frequently in the play sessions, so the authors attribute the reduction to the limit-setting skills along with the therapist's unconditional positive regard toward the boys. The belief was that these two qualities together provided the opportunity for children to self-express within a safe relationship. Furthermore, the follow up, conducted when the boys were in second grade, reported the boys' aggression levels were still reduced, indicating CCPT is effective long-term. These results establish that CCPT is an effective intervention that has long lasting results for children, indicating that implementing CCPT early can assist young children in reducing aggressive behaviors and learning to continue to regulate their emotions.

In a study examining teacher stress and ADHD symptoms, Ray, Schottelkorb, and Tsai (2007) found that children's symptoms of ADHD and teacher stress decreased with CCPT. In this study, school aged children with ADHD demonstrated significant

reductions in ADHD symptoms on the Index of Teaching Stress, thus reducing teacher stress.

Schottelkorb and Ray (2009) used a single-case design to examine the effectiveness of CCPT on ADHD symptoms. Teachers completed the TRF (Achenbach & Roscorla, 2001) and the Conners' Teacher Rating Scale-Revised: Short Form (CTRS-R:S; Conners, 2001) for inclusion in the study. The students had to meet clinical or borderline scores on the ADHD subscale on both assessments to be included in the study. The Direct Observation Form (DOF; Achenbach & Roscorla, 2001) was used three times a week to assess the student on-task behaviors by observers who did not know which child was receiving which treatment. There were four students total who were placed in two different interventions groups. Both interventions consisted of a baseline phase, two intervention phases, and a follow-up phase. One group consisted of two students who completed an intervention of CCPT while the teacher received person-centered teacher consultation. This group consisted of two students who were in kindergarten and first grade and received 24 sessions of CCPT and their teacher received 6 sessions of person-centered teacher consultation (PCTC). The two children participated in three weeks of the baseline phase; 6 weeks of CCPT alone, twice a week; 6 weeks of CCPT with the child and PCTC with the teacher; and three weeks of no intervention. One of the students (kindergarten, Caucasian, male) experienced questionable improvement and the other student (first grade, Caucasian, male) experienced a significant reduction in ADHD symptoms. The second group consisted of two students who were in the first and fifth grade and received 14 sessions of CCPT and a 12-14 sessions of Reading Mentoring

intervention. These children participated in three weeks of the baseline phase; 7 weeks of Reading Mentoring alone, twice a week; 7 weeks of CCPT alone, twice a week; and three weeks of no intervention. One of the students (first grade, Brazilian-American, male) experienced questionable improvement and the other student (fifth grade, Hispanic, male) experienced a significant reduction in ADHD symptoms. This study indicates that CCPT can be effective in the reduction of ADHD symptoms; however, children may need more than 12 sessions of CCPT for the treatment to be effective. The authors suggest that more research needs to be conducted. While the results do indicate that CCPT is effective, this study had many different interventions. The current research only used CCPT as an intervention and used a single case reversal design that allowed the researcher to examine a change in levels three different points in time (when the intervention is introduced, when the intervention is removed, and again when the intervention is reintroduced) to establish whether or not the intervention caused the change in the scores.

Throughout this section, the CCPT has been shown to reduce hyperactive or aggressive behaviors separately. However, CCPT has also been shown to reduce both hyperactive and aggressive behaviors, also called externalizing behaviors. In a case study examining the impact of CCPT on the externalizing behaviors of a second grade male, Cochran, Cochran, Fuss, and Nordling (2010) found that teachers reported CCPT had a significant impact in reducing externalizing behaviors. The TRF (Achenbach & Rescorla, 2001) for the teachers indicated the child was in the clinical range for Total Scores and the Externalizing Subscale with the major concerns in aggressive behavior, social problems, and last, hyperactivity. The CBCL (Achenbach & Rescorla, 2001) for the

parents indicated similar scores. These score either worsened or had no change during the waiting period. Once treatment began, it lasted 9 weeks and included 45-minute sessions, twice a week. The therapist responded to the child in an empathetic manner, even when he tried to argue or push limits. Throughout the play he role-played battles where the therapist would lose or become his servant. As the therapy continued, he invited the therapist to become his partner and eventually moved into play that did not include battles or aggression. The teacher's post-treatment scores on the TRF indicated a significant improvement in his overall behavior, aggression, hyperactivity, and social problems. Parents did not complete the CBCL post treatment.

Child-Centered Play Therapy and the Teacher-Child Relationship

Child-centered play therapy also indirectly affects the teacher-child relationship. The reduction of externalizing behaviors has an impact on the reduction of stress levels for teachers, which, in turn positively affects the teacher-child relationship. Students externalizing behaviors are known to raise the stress levels for teachers (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014; Green, Beszterczey, Katzenstein, Park, & Goring, 2002) and this affects the teacher-child relationship (Jennings & Greenberg , 2009). Research indicates that teacher stress has a negative effect on the academic trajectory of children (Caprara, Dodge, Pastorelli, and Zelli, 2007; Green, Abidin, & Kmetz, 1997). However, CCPT assists in reducing teacher stress by helping the child regulate his emotions and are widely used in the field (Ray, Henson, Schottelkorb, Brown, & Muro, 2008). Because CCPT reduces externalizing behaviors that are stressful to the teacher, this is thought to improve academic achievement. The thought is that

CCPT improves children's self-confidence and this results in the students finding more effective ways to self-direct behaviors, including discovering solutions to academic problems (Carmichael, 2006).

In an effort to address the time required to see changes in child-centered play therapy to affect the teacher-child relationship, Ray, Henson, Schottelkorb, Brown, and Muro (2008) compared the effectiveness of long-term (16 weeks) and short-term (8 weeks, twice a week) CCPT. There were 58 elementary aged students who participated in this study. The interventions took place within the school setting and the children were placed into either the long-term CCPT group (n = 28) or the short-term CCPT group (n = 30). The Index of Teaching Stress (ITS; Abidin, Greene, & Konold, 2004) was used to measure the stress the teacher feels toward a specific child. The results indicated that both lengths of treatment had significant effects over time in improving the teacher-child relationship. While both lengths of treatment improved the teacher-child relationship, post hoc analysis indicated that short term CCPT demonstrated a statistically significant higher effect in the reduction in teacher stress than long term CCPT. This study was not comparing CCPT to another intervention, so the results of this study were not trying to determine if CCPT was effective or not. The finding that the short-term intervention was effective is important to the current research because the intervention will be implemented in the same way, eight weeks, twice a week, for 30 minutes.

Summary

In the exploration of these articles, it is apparent that CCPT is an effective intervention for school-aged children. However when examined closely, it is also

apparent there are gaps in the research. The gap noticed, relevant to the current research, was the ages of the children. The average ages for the meta-analyses were 7.0 years (Bratton et al., 2005), 6.7 years (Lin and Bratton, 2014), 7.8 years (LeBlanc and Ritchie, 2001), and elementary age (Ray et al., 2015). The three studies that focused on ethnic diverse children and the two studies that focused on academic achievement also used an elementary aged sample. While some 4-year-old children were included in the studies that were used in the meta-analysis, the focus was not on the preschool age. Further attention needs to be given to early interventions for children.

This review of the literature has also established CCPT to be a developmentally appropriate and an effective treatment with children who are exhibiting aggressive and/or hyperactive behaviors. The research also indicated that CCPT was effective when compared to no treatment (Ray, Blanco, Sullivan, & Holliman, 2009), was effective when compared to a control group receiving a different treatment, and CCPT demonstrated the same effectiveness as an evidence-based treatment (Schumann, 2004). Child-centered play therapy has also been shown to be a long-term effective treatment with males (Cochran, Cochran, Cholette, & Nordling, 2011) that indirectly affected the teacher-child relationship. Child-centered play therapy was shown to reduce externalizing behaviors, thus it reduced teacher stress and increased teacher-child relationship (Ray, Henson, Schottelkorb, Brown, & Muro, 2008). However, there was only one study that demonstrated effectiveness in reducing externalizing behaviors with preschoolers (Bratton et al., 2013), indicating the need for more research with this age group.

Summary

Working with children requires a therapist to consider a developmentally appropriate therapeutic modality that takes into account language barriers, includes fantasy play, and focuses on the relationship between counselors and children. Directive and nondirective play therapy interventions have been shown to take most of these factors into account and to be effective with aggressive and hyperactive children. However, nondirective modalities have been shown to be more effective for children. It is important to have an effective evidence-based therapeutic intervention for young children who exhibit externalizing behaviors. This is particularly true for preschool children who need services to assist with externalizing behaviors. Numerous studies have indicated that CCPT is one of the most used and most effective therapy for elementary aged children in reducing externalizing behaviors and has also been shown to increase academic functioning. This could be because CCPT focuses on the social and emotional issues children face that triggers the externalizing behaviors that reduce academic functioning. While CCPT has been shown to be effective with kindergarten and elementary school aged children, there is little research focused on preschoolers and no research focusing only on preschool male children and CCPT. With the mental health issues in the United States, there is a need for interventions that are developmentally appropriate for young children. However, it is not enough for interventions to be developmentally appropriate, due to the growing number of children in poverty in the United States and the issues they encounter, the interventions must also be sensitive to their needs. The purpose of this study is to fill in the gap in the literature and examine the effect of CCPT on preschool

males with externalizing behaviors in the classroom during center time and instructional time.

CHAPTER III: METHODOLOGY

The purpose of this study was to assess the effect of child-centered play therapy (CCPT) on the externalizing behaviors of low-income preschool males in two different settings: center time and group instruction time. The following sections of this chapter describe the methodology for this study including details about the participants, independent observers, setting and materials, the researcher, data collection procedures, data analysis, and experimental design that were used.

Participants

Participants of this study were male children in a three and four-year-old preschool class, exhibiting high levels of externalizing behaviors as evidenced by scoring in the top five highest score in the class, on the Externalizing Behavior Subscale of the Caregiver/Teacher Report form of the Child Behavior Checklist (See appendix A; C-TRF 1.5-5; Achenbach & Rescorla, 2001). Eleven children were enrolled in the three and four-year-old preschool class and all eight males (53.33%) were invited to participate. Of these, five males met the inclusion criteria. The preschool teacher and the lead investigator explained the study and obtained written informed consent for all eight male students in the class. Exclusion criteria for participants included a formal diagnosis, being female, poor attendance, and receiving counseling services outside of the preschool.

Student A was a 3-year-old Caucasian male. According to the C-TRF 1.5-5 completed by the teacher he scored 42, the highest score in the classroom. Additionally, the teacher reported that Student A was aggressive towards other children, and disruptive during group and activities. She defined aggression as hitting, taking toys, pushing, and

throwing objects. She defined disruptive as fidgeting during group time, refusing to participate or clean up when asked, yelling, pretending to shoot other children, and distracting the other children. She reported that, although he was three, he often acted like he was two because he ignored instruction, played with his food, and many times acted as if he could not control his emotions as evidenced by him hitting, yelling, kicking, and crying when he did not get his way. According to the Index of Teaching Stress (ITS; Abidin, Green, & Konold, 2004; See Appendix C), the teacher reported a total stress score of 161 (53%). Although this score was low, she reported that he changed the dynamics of the classroom and she often felt unsure of how to handle his behaviors, felt overwhelmed, and stressed.

Student B was a 3-year-old Caucasian male. According to the C-TRF 1.5-5 completed by the teacher he scored 26, the fourth highest score in the classroom. However, this student began the intervention second due to increased aggression levels and per the teacher's request. The teacher reported that Student B was aggressive. She defined Student B's aggression as hitting, pushing, and throwing objects. She also reported that Student B was disruptive and defined disruption as refusing to listen to instruction, yelling curse words, showing his "bottom" to the other children and urinating on the playground. She reported that he became angry easily and had difficulty controlling his emotions as evidenced by him hitting her, hitting others, yelling curse words, and crying when he did not get his way. According to the Index of Teaching Stress (ITS; Abidin, Green, & Konold, 2004; See Appendix C), the teacher reported a total stress score of 120 (32%). Although this score was low, she reported that he taught

other children “potty words” and his disruptive nature put a significant amount of stress on her and “made her job less enjoyable”.

While the other three children did not receive the intervention, their externalizing behavior scores were taken on the C-TRF 1.5-5 throughout the study. Student C was a 4-year-old Caucasian Male. He was the largest and oldest child in the class. According to the C-TRF 1.5-5 completed by the teacher he scored 34, the third highest score in the classroom. The teacher reported that he often hit other children, stared fights, would urinate on the playground, would not listen to instruction, and screamed when he did not get his way. As the study continued, Student C seemed to have two different, very distinct personalities. At times, he was very hyper, as if a motor was driving him; and other days, he was very calm and zoned out. According to the teacher’s report, she noticed this as well, but reported he was not medicated. According to the ITS (Abidin, Green, & Konold, 2004), the teacher reported a score of 147. Although this score was low, she reported that on his “hyper days” he often disrupted the classroom to the point where she had to take attention away from the other children and focus attention on him.

Student D was a 3-year-old African American Male. He was the smallest and youngest child in the class. His verbal skills seemed to be delayed as evidenced by him speaking in a way that he was not understandable. According to the C-TRF 1.5-5 completed by the teacher he scored 39, the second highest score in the classroom. The teacher reported that he ate nonfood items and that he often hit other children and screamed when he did not get his way. According to the ITS (Abidin, Green, & Konold, 2004), the teacher reported a total stress score of 156. Although this score was low, she

reported that she often worried about his developmental delays and she had to expend a lot of energy to help him catch up to the other children.

Student E was a 4-year-old African American Male. He was the older brother of Student B and often took a caretaker role. According to the C-TRF 1.5-5 completed by the teacher he scored 21, the fifth highest score in the classroom. The teacher reported that he ate nonfood items and that he sometimes hit other children, but only when provoked. The teacher reported he often did not seem engaged in instruction time "as if he were in another world". He did not receive the ITS (Abidin, Green, & Konold, 2004) assessment because it was determined that he would not receive the intervention due to his low scores on the TRF 1.5-5. However, the teacher reported that she often worried about him.

Setting and Materials

This study was conducted in a preschool located in the urban, southeast region of the United States with children in the three and four year old class. All the children in the preschool were from a low socio-economic status and qualified to receive free breakfast and lunch. According to the United States Department of Agriculture, Food and Nutrition Service (https://www.fns.usda.gov/fr-032316) the family income requirements to be eligible for free breakfast and lunch are based on household size. This ranges between annual incomes of $15.444 (roughly $1,268 a week) for a one-member household to an annual income of $53,157 (roughly $4,430 a week) for an eight-member household. There were 15 children in the facility ranging from ages 12 months to four years old. Of these 15 students, 11 were in the three and four year old preschool class. The student

population consisted of four (26.67%) African American males, four (26.67%) Caucasian males, one (6.67%) Caucasian female, two (13.33) Latino female, and four (26.67%) African-American females. None of the children had a formal diagnosis, however three children were nonverbal and could potentially meet the criteria for Autism. These children were not included in the study.

The researcher used a CCPT tote bag based on Landreth's (2012) guidelines of appropriate toys for child-centered play therapy (CCPT). Toys included real-life toys, aggressive-release toys, and creative expression toys. Real-life toys symbolized items in the real world such as dolls, families, cars, play money, and puppets. Aggressive-release toys included toys that allowed the child to release strong emotions and included toys such as toy knifes, toy guns, a bop bag, and toy soldiers. Creative expression toys included toys that encouraged creativity and included toys such as paint, paper, sand, markers, crayons, and whiteboard/chalkboard. The room available was in the back of the facility beside the bathroom. There was very little privacy from the other children. There was one window, the walls were plain white, there were two shelves around 3-feet high and 6-feet long, and other toys were in the room. Each play session, the two shelves were moved, a queen size quilt was placed on the floor, and the toys were placed on the shelves and quilt to create the play area. Many of the other toys were also moved each play session and to avoid distractions from other toys for the child. It took around 10 to 15 minutes to set up the play area.

Independent Observers

Two independent observers were chosen to observe and assess all of the children for the data analysis. The two observers were students currently completing their masters in counseling. The primary observer was a Caucasian female who attended Gordon Conwell. The observer that provided inter-observer agreement (IOA; Cooper, 1981) was an African American female who attended Liberty University. The primary researcher supervised both interns for one semester in their practicum and they were both completing their second internship with the primary researcher during the data collection period.

Researcher

The primary researcher and interventionist was a Caucasian female who worked with a variety of clients since 1997. She received play therapy training and supervision at the University of North Carolina in Charlotte during her Master's degree program. She graduated with a MA in Community Counseling and became a National Certified Counselor (NCC) in 1997. She became a Licensed Professional Counselor (LPC) in 2000 and worked with young children in Intensive In-home and Private practice. She earned her Licensed Professional Counselor Supervisor (LPCS) in 2013 and currently supervises students and provisionally licensed counselors in play therapy at her private practice. She is currently a doctoral student at University in North Carolina, taking play therapy classes, working as a teaching assistant in play therapy classes, teaching, and conducting research in play therapy.

Data Collection Procedures

Dependent Variable

The dependent variable for this study was the externalizing behaviors of the preschool students, which included aggressive and hyperactive behaviors. Externalizing behaviors were measured twice a week by an independent observer on Monday and Thursday, days the intervention is not implemented. The independent observer did not know which of the students were receiving the intervention. The assessment used was the Externalizing Behavior subscale of the Caregiver/Teacher Report form of the Child Behavior Checklist 1.5-5 (C-TRF 1.5-5: Achenbach & Rescorla, 2001; See Appendix A). The observers rated each statement on a 3-point Likert scale from 0 - 2 (0 = Not True, 1 = Sometimes True, 2 = Often True). This assessment was chosen because it measured the levels of aggressive and hyperactive behaviors of the children, was created to assess children four years old and younger who attend daycare and preschool, and the Teacher Report Form (Achenbach & Rescorla, 2001) for older children was used in previous research examining the effect of CCPT on aggressive behaviors (i.e., Ray, Blanco, Sullivan, & Holliman, 2009).

There were 99 items on the full version of the C-TRF/1.5-5 (Achenbach & Rescorla, 2001) that included 82 items from the CBCL and 17 additional items based on literature, teacher report, and consultation with experts in the field. The C-TRF/1.5-5 was part of the Achenbach System of Empirically Based Assessment (ASEBA) and widely used for rating individual children in-group settings (i.e., Cochran, Cochran, Fuss, & Nordling, 2010; Ray et al., 2009). Excellent reliability and validity were reported for the

C-TRF/1.5-5. The test-retest reliabilities scores for Total Problems (r = .88) and the Externalizing Problems (r = .89) on the C-TRF1.5-5 were high (based on Fisher's z; Huck, 2012). The cross-informant agreement for Total Problems (r = .72) and the Externalizing Problems (r = .79) was also high. This indicated that Rater two scored the child in the clinical range if Rater one scored the child in the clinical range. The C-TRF/1.5-5 (Achenbach & Rescorla, 2001) stability correlations averaged .59 and externalizing behaviors averaged .40 over a 3-month period (significant at $p < 0.01$) indicating no significant change in the scores over a three-month period. Content validity means that the items distinguished significantly ($p < .01$) between children who were referred to services and those who did not (Achenbach & Rescorla, 2001). The probability of the Total Problems t score increased steadily with the subscale scores, indicating high criterion-related validity. The C-TRF/1.5-5 (Achenbach & Rescorla, 2001) correlated significantly with the current CBCL for preschoolers, previous CBCL and other studies measuring behavior problems with preschoolers indicating high construct validity of the Total Problems (Achenbach & Rescorla, 2001).

The C-TRF 1.5-5 was used to measure the hyperactive and aggressive behaviors during instructional time and center time. The observer used the entire Externalizing Behavior subscale of the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) for instructional time and center time. There were 34 items on the externalizing behavior subscale. The observer observed the children for 15 minutes during center time and 15 minutes during group instructional time and completed two C-TRF 1.5-5 assessments per child twice a week. More specifically, using the 34 items on the C-TRF 1.5-5, the observer checked

each behavior that occurred during instructional time on the C-TRF 1.5-5 form and checked each behavior that occurred during center time on a separate C-TRF 1.5-5. If the behavior did not occur, the item was not checked. At the end of the observation, the observer added up the behaviors on each assessment form for a score on the C-TRF 1.5-5 for instructional time and a score on the C-TRF 1.5-5 for center time. The C-TRF 1.5-5 took approximately 2 minutes per assessment for the observer to complete.

The total C-TRF 1.5-5 was completed pre and post intervention by the teacher. The assessment was completed pre-intervention to make decisions about inclusion into the CCPT sessions. The five males who scored the highest were considered for the intervention and included in the data collection. The assessment was completed post-intervention to examine the teacher's perception of the change in the children's behavior. Two independent observers completed the total C-TRF 1.5-5, twice a week, throughout the study to assess the children's externalizing behaviors. One observer was the primary observer and the other observer was used each session to obtain IOA.

Inter-Observer Agreement

Behaviors must be specific and objective (Cooper, 1981). According to Hall (as cited in Cooper, 1981), IOA was defined as "The degree to which independent observers agree on what they have observed in the same subject during the same observation session" (p. 34). To show that behaviors were objective, IOA was collected for the C-TRF 1.5-5 (See Appendix A; Achenbach & Rescorla, 2001) Inter-observer agreement (IOA) was taken 94% of the measures. Inter-observer agreement was collected all but two times the C-TRF 1.5-5 was completed; including once when the second observer was

sick and once when she was out of town. For the researcher to claim IOA, there needed to be an average of 80% or above (Cooper, 1981; Ray, 2011). Inter-observer agreement was reported in percentage using an item-by-item comparison outlined by Cooper and calculated by "dividing the number of agreements by the number of agreements plus disagreements and multiplying by 100" (p. 34).

The teacher knew which children were receiving treatment, so two independent observers were chosen to observe and assess all of the children for the data analysis. Both observers received training on the assessment before the study by completing mock assessments of children from a different preschool, comparing the assessments, and operationally defining each item. The researcher and the two observers all completed the practice C-TRF 1.5-5 three times with two children. The researcher scored her assessment, the assessment completed by the first observer and the assessment completed by the second observer. All three assessments were compared using an item-by-item comparison. The researcher and two independent observers then reviewed the practice C-TRF 1.5-5 and operationally defined each item to ensure the observers and the researcher were clear about the behaviors. This process occurred until there was 80% or above agreement on the observed behaviors. Once IOA was established with children outside of the preschool, the observers and the researcher observed the children in the preschool and practiced scoring the children on the C-TRF 1.5-5. Once IOA was established, one observer was randomly selected and used as the primary observer to assess the children during the study. However, both observers continued to observe and assess the children, twice a week, at the same time, to continue to check for IOA.

Social Validity Data

Social validity was defined as "the social importance and acceptability of treatment goals, procedures, and outcomes" (Foster & Mash, 1999, p. 1). It was important to the design because it indicated the community accepted the intervention (Wolf, 1978) and the intervention addressed the needs of the participants in the study (Schwartz & Baer, 1991). Social validity was measured using the teacher's report on the Index of Teaching Stress (ITS; Abidin, Green, & Konold, 2004; See Appendix C), the teacher's report on the C-TRF 1.5-5 (See Appendix A; Achenbach & Rescorla, 2001), and a questionnaire and interview conducted by the researcher with the teacher (See Appendix D) to determine the teacher's perceptions of the CCPT procedures and the findings of the study.

Index of Teaching Stress. Teacher stress was measured because students externalizing behaviors are known to raise the stress levels for teachers (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014; Green, Beszterczey, Katzenstein, Park, & Goring, 2002) and this affects the teacher-child relationship (Jennings & Greenberg , 2009). Research indicated that teacher stress had a negative effect on the academic trajectory of children (Caprara, Dodge, Pastorelli, and Zelli, 2007; Green, Abidin, & Kmetz, 1997). However, CCPT has been shown to assist in reducing teacher stress by helping the child regulate his emotions and are widely used in the field (Ray, Henson, Schottelkorb, Brown, & Muro, 2008).

Teacher stress was measured pre and post intervention by the Index of Teaching Stress (ITS; Abidin, Green, & Konold, 2004) to assess social validity. The ITS was

created to measure teacher feelings of self-efficacy in the student-teacher relationship with regards to individual student behaviors focusing on the teacher stress level with a specific child. It has been used to assess teacher stress in preschool to 12th grade. The total score was used. The instrument consisted of 90 items in three scales, which consisted of 16 items on Attention-Deficit/Hyperactivity Disorder, 31 items on Student Characteristics Domain, and 43 items on Teacher Characteristics Domain. The items on the Student Characteristics Domain consisted of the following scales: Emotional Lability/Low Adaptability, Anxiety/Withdrawal, Low Ability/Learning Disability, and Aggressiveness/Conduct Disorder. The items on the Teacher Characteristics Domain included the following scales: Sense of Competence/Need for Support, Loss of Satisfaction From Teaching, Disruption of the Teaching Process, and Frustration Working With Parents. There were two different parts with two different 5-point Likert scales. The responses for part A ranged from 1 – Never Stressful to 5 – Very Often Stressful and the responses for part B ranged from 1 – Never Distressing to 5 – Very Distressing. The instrument had high reliability and validity. Internal consistency reliability alpha was greater than .90 for the ITS domains and Total score for the selected students. Using this same sample, 42 white teachers rated test-retest reliability in 1-month intervals. Based on the literature, there was evidence the instrument was internally consistent. The instrument was also fairly sensitive to student behavior that is "episodic" in nature. Content validity was established through teacher focus groups. Discriminate validity indicated that the scores are not related to teacher's general stress. Concurrent validity indicated that scores are positively connected to student social skills and

negatively connected to the student-teacher relationship. Scores were also sensitive to interventions such as CCPT.

During baseline, before the first CCPT intervention began with Student A, the teacher completed the ITS on the four children with the highest score on the TRF 1.5-5. The teacher reported she would worry about Student E (who scored the fifth highest on the TRF 1.5-5), however, she was not stressed by his behavior. The ITS was completed to determine the stress level of the teacher for each child. The teacher completed the ITS on the three of the four children, again, after Student A finished the intervention for the second time to determine if the teacher's stress was reduced after the intervention. This included Student A, Student B, and Student C. The teacher did not complete the ITS on Student D because she began to have health issues.

Externalizing Behavior Subscale of the Caregiver-Teacher Report/1.5-5. The C-TRF 1.5-5 (See Appendix A; Achenbach & Rescorla, 2001) was completed pre and post intervention by the teacher for all five students. This was completed pre-baseline and completed again one week after the second intervention was completed with Student A to determine the teacher's perceptions of the children's externalizing behaviors from pre to post intervention.

Teacher questionnaire and interview. The researcher interviewed the teacher to assess her perceptions of the effectiveness of the intervention after Student A finished the intervention for the second time (See Appendix D). The questionnaire was adapted from prior dissertations (Geddes, 2015; Lo, 2003) and consisted of 10 questions using a Likert scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree) and

four open-ended questions to more fully ascertain the teacher's perceptions. The teacher completed the first 10 questions by herself after the researcher explained the assessment. The last four questions were open ended and the researcher asked these questions like an interview. These last questions allowed the teacher to more fully describe her perceptions of the intervention.

Experimental Design

The experimental design for this study began as a multiple-baseline across students design. This design was chosen to measure the change in behavior of two or more individuals using a staggered A-B-A design. Five male students in the class were identified for participation in the study. The A-B-A design included a baseline phase (A) with no intervention, the treatment (or intervention) phase (B), and a maintenance (or withdrawal) phase (A) where the intervention has ceased. This design was originally chosen to examine whether the externalizing behavior scores would drop during the intervention phase and remain steady during the withdrawal phase. However, once the intervention of CCPT began with the first child, there appeared to be induction in the remaining students, meaning the intervention not only affected the student receiving the intervention, but also affected the other four students. To test this idea, the design was changed to a reversal design. This design included an initial baseline (A) phase where Student A was observed without the CCPT intervention. Then after the baseline phase Student A entered into the first CCPT intervention (B) phase and completed 16 sessions of CCPT. After the 16 sessions of the CCPT intervention, Student A entered into a second baseline (A) phase without the intervention. After the second baseline, Student A

then began a second phase of the CCPT intervention (B). This design still allowed the researcher the potential to establish a functional relation by observing whether the externalizing behavior scores of Student A would drop during Student A's first intervention phase, rise again during Student A's second baseline phase, and drop again during Student A's second intervention phase, as well as its effect on the remaining students.

The children were selected for the study using the teacher's report on the C-TRF 1.5-5 (Appendix A; Achenbach & Rescorla, 2001). The 5 males with the highest scores who received parental consent; were eligible to participate in the study. Both Student A and Student B received the intervention. Student A followed the reversal design, while Student B completed the original multiple-baseline across students design using a staggered A-B-A design for this study. Student A began the CCPT intervention after the data points on the C-TRF 1.5-5 became predictable and stable. This took three baseline data points. The intervention phase consisted of 16 sessions of the CCPT intervention twice a week for Student A. This number of sessions was based on the number used by Blanco and Ray (2011). Student B began intervention after three successive intervention data points on the assessment indicated a reduction in Student A's externalizing behaviors as seen by a decrease in the score of the C-TRF 1.5-5 as assessed by the observer. This was determined by examining the data point graph created in an Excel spreadsheet. After 16 sessions, Student A moved to the second baseline phase. Student B continued in the intervention phase until he completed 16 sessions. Then Student B moved to a maintenance phase where the intervention was removed. At this point,

Student A began the intervention again until there was a decrease in trend and the scores became stable. Throughout the study, the independent observer assessed all the students twice a week. These phases will be detailed more fully throughout the following sections.

Procedures

An application for approval by the Institutional Review Board for Research with Human Subjects at the University of North Carolina (IRB) was completed and approved before recruitment of participants. Approval from the Preschool director/owner was also obtained before the study began (see Appendix E).

Informed consent. All the male students in the three and 4-year-old class were invited to participate in the initial assessment. Because all the male students were observed and assessed by the independent observers, a flyer (See Appendix F) and a parental informed consent (See Appendix G) was sent home for all the male students in the class. The informed consent included information about the study, benefits and risks of the study, and contact information of the primary researcher and dissertation advisor. An informed consent signed by the parent was required for the child to be assessed by the teacher and observer on the C-TRF 1.5-5. When the informed consent was sent out to the parents, it indicated the study was focusing on minority males. However, after the teacher assessed the children on the C-TRF 1.5-5, based on the scores, the child who scored the highest on the C-TRF 1.5-5 was Caucasian. Because of this, the study did not focus on minority males. The researcher was be available at pickup and drop off several days and answered questions parents had about the study. The researcher also obtained informed consent from the teacher because of her assessment of the children for inclusion in the

study and the input on the social validity measures (See Appendix H) and the observers because of the data they collected on the observations (See Appendix I). Both observers received training on the C-TRF 1.5-5 assessment, before the study, by completing mock assessments of children from a different preschool to assess for inter-observer agreement. Parental consent forms were collected for the children who the independent observers observed before the study began (See Appendix J). All the parents consented for their child to participate in the study. Before the intervention began, the researcher/interventionist and her faculty advisor rated three CCPT clips using the Play Therapy Skills Checklist (PTSC; Ray, 2011; See Appendix B) to assess for procedural reliability. This occurred with children not associated with the current study as suggested by Ray (2011). Parental consent was collected for those children as well (See Appendix K).

Pre-baseline. Before baseline began, the primary researcher explained, the purpose of the study, the expectations, and the assessments to the teacher and observers. The assessment's Likert scale was explained to the teachers. The observers practiced observing children, rating children using the Likert scale, and assessing children in a different preschool so they were comfortable with the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) assessment and determined decision rules for rating to obtain the required 80% IOA. After the informed consent was obtained, the teacher completed the C-TRF 1.5-5 to assess all the male children for externalizing behavior. The five male children who exhibited the highest scores of externalizing behaviors as reported by the teacher on the C-TRF 1.5-5 were eligible for inclusion in the study.

First Baseline. During the baseline assessment, the five students' behavior were observed and recorded without the treatment by the independent observer, who did not know which child would receive the CCPT intervention.. The observer rated all five children in the study using the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) twice a week. The baseline phase had at five observations, however, Student A was absent twice so he was observed three times and three data points were recorded, as recommended by Kennedy (2005). During this phase, the teacher also completed the ITS on four of the five students, to determine her stress level (Abidin, Green, & Konold, 2004).

First Intervention. The intervention took place in a designated space that was used as the playroom. The CCPT intervention followed the procedures based on Landreth (2012) found in Ray's (2011) treatment manual. During the intervention phase, the independent observer continued to observe the five male in the classroom for 30 minutes. This consisted of 15 minutes of center time followed by 15 minutes of instruction time. The observer completed the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) for each child immediately following center time and again immediately following the instructional time. The observer did this twice a week on the days the treatment was not provided. The independent observer rated all five male children in the class and did not know which male child was receiving the CCPT intervention.

The child who scored the highest on the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) began the intervention first. The teacher-reported score on the C-TRF 1.5-5 for Student A was the highest in the class, so once Student A's baseline scores were stable, the primary researcher began the CCPT intervention with Student A. Student A received

16 thirty-minute sessions of CCPT, twice a week, in the first intervention. While Student A began in the intervention, the remaining four students remained in the baseline phase, were observed, and their baseline behaviors continued to be assessed twice a week.

When Student A's scores demonstrated a consecutive drop in three data points on the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) in instructional time, as reported by the independent observer, the second student began the intervention. Once Student A's scores dropped three consecutive points in instructional time, the teacher requested Student B be chosen to begin the intervention next. Student B's teacher-reported score on the TRF 1.5-5 was the fourth highest in the class at the beginning of the study. Student B received 16 thirty-minute sessions of CCPT total, occurring twice a week until session 9 and then increased to three times a week. Once the 16 sessions of the CCPT intervention phase was over for Student A, he entered into the second baseline phase. Once the 16 sessions of the CCPT intervention was over for Student B, he entered into the maintenance phase.

Second Baseline and Maintenance. After Student A and Student B received 16 sessions of CCPT, they entered into either the second baseline phase or the maintenance phase. Student A, entered into a second baseline phase where he was observed seven times without the intervention. Student B, entered into the maintenance phase where he was observed without the intervention for the remainder of the study. The independent observers continued to complete the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) twice a week for the five students participating in the study.

Second Intervention. After Student A completed the second baseline phase, he began a second intervention phase. He received the CCPT intervention until his scores were stable. He received five 30-minute sessions of the CCPT intervention. One week after the second intervention phase ended for Student A, the teacher began completing the ITS (Abidin, Green, & Konold, 2004) for Student A, Student B, and Student C to analyze the teacher's stress level and the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) to analyze the teacher's perception of the child's behavior. She did not complete assessment on Student D because she was having health issues.

Procedural Reliability. The Play Therapy Skills Checklist (PTSC; Ray, 2011) was used to assess the procedural reliability of the intervention of CCPT (See Appendix B). The primary researcher was also the interventionist. The procedure followed Ray's (2011) guidelines to insure the reliability of the interventionist's CCPT skills during the study. Before the intervention began, the researcher/interventionist and her faculty advisor practiced rating CCPT clips with two children not associated with the current study as suggested by Ray (2011). According to Ray (2011), 90% of the CCPT skills were necessary to retain the skill level required for the intervention to be effective. Once the intervention began, the researcher and her faculty advisor, Dr. Phyllis Post, continued to check for procedural reliability. Student A's parents would not consent to videotaping so three entire 30 minute session were observed live. This occurred two times in CCPT 1 and once in CCPT 2. Student B's parents did consent to videotaping, however, to remain consistent, three entire 30 minute session were watched. This occurred three times during the CCPT intervention.

Data Analysis

Data was analyzed visually on two line graphs per child; including one line graph for instructional time and one line graph for center time. The first line graph was used to track the behaviors during the instructional time and was used to determine when the next child was included in the intervention. The second line graph was used to track the behaviors for center time. These graphs assisted with tracking progress, presenting results, and assisted in the decision to change the design from a multiple baseline between students to a reversal design. The first baseline, first CCPT intervention, second baseline and second CCPT intervention phases were labeled for Student A and the data points were joined on the line within the conditions but not between conditions (Cooper, 1981).

Change was determined by visual analysis of the data across and within each phase to determine if prediction, verification, and replication were present. This was assessed through the level, trend, and variability at the end of the maintenance phase to determine if a functional relation existed between the intervention and the change in behavior (Swank, Shin, Cabrita, Cheung, & Rivers, 2015). The level refers to the mean of each phase, the trend refers to the slope of the data, and the variability refers to the difference between the trend and each individual data point within a phase. Both observers' scores were tracked on the same graph with a different symbol and a separate graph to indicate IOA in center time and group instructional time for each child was included.

Summary

The purpose of this chapter was to outline the methodology used in this study. This included the participants, setting and materials, the researcher, data collection procedures, experimental design, and data analysis that were used. Using the single case design described by Cooper (1981), visual analysis of the graphed data points from the C-TRF 1.5-5 (Achenbach & Rescorla, 2001) scores assessed if CCPT had an effect on the externalizing behaviors of males in a three and four-year-old preschool class.

CHAPTER IV: RESULTS

The purpose of this study was to investigate the effect of child-centered play therapy (CCPT) on the externalizing behaviors of preschool males in two different settings: center time and group instruction time. The first section of this chapter describes the research design used. The second section describes inter-observer agreement (IOA) for group instructional time and center time. The third section examines procedural reliability of the CCPT intervention. The fourth section outlines results for the dependent variable, externalizing behaviors, during instructional and center time. Finally, the last section discusses social validity for the teacher. This chapter concludes with a summary of findings.

Inter-Observer Agreement

Inter-Observer Agreement data were collected an average of 94% of the observations of C-TRF 1.5-5 in both group instructional time and center time for all five children. IOA was determined by completing an item-by-item comparison of TRF 1.5-5 scored by observer 1 and the TRF 1.5-5 scored by observer 2

During instructional time, Student A was observed 28 total times and 26 times by both observers so IOA data were collected 93% of the observations. The mean IOA score for Student A was 92.27% (range 76%-100%). Student B was observed 31 total times and 29 times by both observers, so IOA data were collected 94% of the observations. The mean IOA score for Student B was 91.41% (range 76%-100%). Student C was observed 30 total times and 28 times by both observers so IOA data were collected 93% of the observations. The mean IOA score for Student C was 91.41% (range 71%-100%).

Student D was observed 31 total times and 29 times by both observers, so IOA data were collected 94% of the observations. The mean IOA score for Student D was 91.21% (range 73%-100%). Student E was observed 31 total times and 29 times by both observers, so IOA data were collected 94% of the observations. The mean IOA score for Student E was 92.55% (range 68%-100%).

During center time, Student A was observed 27 total times and 25 times by both observers, so IOA data were collected 93% of the observations. The mean IOA score of Student A was 94.00% (range 82%-100%). Student B was observed 30 total times and 28 times by both observers, so IOA data were collected 93% of the observations. The mean IOA score of Student B was 94% (range 79%-100%). Student C was observed 29 total times and 27 times by both observers, so, IOA data were collected 93% of the observations. The mean IOA score of Student C was 93% (range 71%-100%). Student D was observed 31 total times and 29 times by both observers, so IOA data were collected 94% of the observations. The mean IOA score of Student D was 95% (range 79%-100%). Student E was observed 31 total times and 29 times by both observers, so IOA data were collected 94% of the observations. The mean IOA score of Student E was 94% (range 79%-100%).

Procedural Reliability

Procedural reliability data were collected for the CCPT intervention throughout the intervention phase using the Play Therapy Skills Checklist (PTSC; Ray, 2011) found in Appendix B. Student A's parents would not consent to videotaping so the entire 30 minute session was observed live. This occurred two times in CCPT 1 and once in CCPT

2. For Student A, 100% of responses used were CCPT responses. Student B's parents did consent to videotaping, however, to remain consistent, the entire 30 minute session was watched. This occurred three times during the CCPT intervention. For Student B, 100% of responses used were CCPT responses.

Effects of CCPT on Externalizing Behaviors in Instructional Time

The effects of CCPT on externalizing behaviors during instructional time are shown in Figure 1 and Table 1. After two observations of the students, it was determined to use the scores from instructional time to make determinations about Student A's movement from the first baseline to CCPT 1 and Student B's entrance into intervention. Student A received 16 sessions of CCPT, twice a week, in the first intervention and Student B received 16 sessions of CCPT total occurring twice a week until session 9 and then increased to three times a week. Figure 1 illustrates the scores from the Externalizing Behavior Subscale of the TRF 1.5-5 taken twice a week during instructional time, for each child. Additionally, the mean score of each phase is demonstrated with a solid horizontal line on the graph. Individual results for each student will be discussed followed by the overall results for the class.

Student A. The teacher-reported score on the TRF 1.5-5 for Student A was the highest in the class. Because of this, the teacher requested he be chosen to begin the intervention first. During the first baseline, Student A's scores ranged from 28-39 with a mean of 34.3. During the first CCPT intervention, Student A's scores decreased, ranging from 7-34 with a mean score of 15.1. During the second baseline, Student A's scores rose slightly, ranging from 12-23 with a mean of 18.1. Finally, during the second CCPT

intervention, Student A's scores rose slightly again, ranging from 9-27 with a mean of 18.1. All scores in this phase remained below the first baseline mean score of 34.3.

Student B. Student B's teacher-reported scores on the TRF 1.5-5 was the fourth highest in the class at the beginning of the study. Once Student A's scores dropped three consecutive points in instructional time, the teacher requested Student B be chosen to begin the intervention next. Student B completed the original multiple-baseline across students design using a staggered A-B-A design for this study. While there were 16 sessions of CCPT for Student B, there were only 13 observations for Student B in the CCPT intervention phase, because the intervention was increased to three times a week after 9 sessions, but the observation sessions remained at two times a week. Student B's section will first include his scores during the multiple-baseline across students design examining his baseline (A), intervention (B), and maintenance phase (B). Then Student B's section will examine Student B's scores throughout Student A's reversal design that included a baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT intervention phase to examine the theory of induction.

Student B completed multiple-baseline across students design using a baseline phase (A), the CCPT intervention (B), and a maintenance phase (A). During Student B's baseline, Student B's scores ranged from 15-40 with a mean of 24.5, but there was a descending trend in the therapeutic direction that corresponded with changes in Student A in the first CCPT intervention. During the CCPT intervention, Student B's scores decreased with a range of 10-31 with a mean of 16.5. Finally, during the maintenance phase, Student B's scores rose again ranging from 13-23 with a mean of 17.2.

It appeared the intervention did demonstrate an effect for Student B's externalizing behaviors in the multiple-baseline across students design, however, it also appeared that Student B's observer-reported scores on the Externalizing Behavior Subscale of the TRF 1.5-5 were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student B's scores were examined in relation to Student A's first baseline (A), first CCPT intervention, second baseline, and second CCPT intervention phases (Figure 1 and Table 1). During Student A's baseline phase, Student B's scores ranged from 26-31 with a mean of 28.0. During Student A's first CCPT intervention, Student B's scores decreased, ranging from 10-40 with a mean of 18.3. During Student A's second baseline phase, Student B's scores rose slightly, ranging from 13-31 with a mean of 19.6. The ending of Student A's second baseline phase coincided with the ending of Student B's CCPT intervention phase. Finally, during Student A's second CCPT intervention, Student B's scores decreased slightly, ranging from 13-23 with a mean of 17.2.

Student C. Student C did not receive the intervention, therefore, this section will examine Student C's observer-reported scores in relation to Student A's phases (See Figure 1 and Table 1). It appeared that Student C's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student C's scores were examined in relation to Student A's first baseline (A), first CCPT intervention, second baseline, and second CCPT intervention phases (Figure 1 and Table 1). During Student A's first baseline phase, Student C's scores ranged from 26-37 with a mean of 32.0. During Student A's first CCPT

intervention, Student C's scores decreased, ranging from 10-24 with a mean of 16.2. During Student A's second baseline phase, Student C's scores rose slightly, ranging from 12-23 with a mean of 18.8. Finally, during Student A's second CCPT intervention, Student C's scores decreased again, ranging from 12-21 with a mean of 14.6.

Student D. Student D did not receive the intervention, therefore, this section will examine Student D's observer-reported scores in relation to Student A's phases (See Figure 1 and Table 1). It appeared that Student D's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student D's scores were examined in relation to Student A's first baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT intervention phases (B) and are illustrated in Table 1. During Student A's first baseline phase, Student D's scores ranged from 22-46 with a mean of 35.3. During Student A's first CCPT intervention, Student D's scores decreased, ranging from 6-28 with a mean of 15.3. During Student A's second baseline phase, Student D's scores ranged from 9-16 with a mean of 12.4. Finally, during Student A's second CCPT intervention, Student D's scores decreased slightly, ranging from 11-15 with a mean of 12.2.

Student E. Student E did not receive the intervention, therefore, this section will examine Student E's observer-reported scores in relation to Student A's phases (See Figure 1 and Table 1). It appeared that Student E's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student E's scores were examined in relation to Student A's first baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT

intervention phases (B) and are illustrated in Figure 1 and Table 1. During Student A's baseline phase, Student E's scores ranged from 12-32 with a mean of 25.2. During Student A's first CCPT intervention, Student E's scores decreased, ranging from 5-15 with a mean of 8.0. During Student A's second baseline phase, Student E's scores increased, ranging from 5-19 with a mean of 10.6. Finally, during Student A's second CCPT intervention, Student B's scores decreased again, ranging from 6-13 with a mean of 8.0.

Overall Results. Student A and Student B received the intervention and it appeared to demonstrate a functional relation for Student A. It also seemed that Student A's movement in and out of intervention effected the externalizing behaviors of the other four male students in the class as seen in Figure 1 and Table 1. The five students included in the study mean scores decreased when Student A began the first CCPT intervention and the student's scores remained below their first baseline mean throughout the remaining phases. Student A, Student B, Student C, and Student E's mean score rose during the second baseline while Student D's mean score dropped. Student A's mean score increased slightly while the four remaining student's mean scores decreased in the second CCPT intervention.

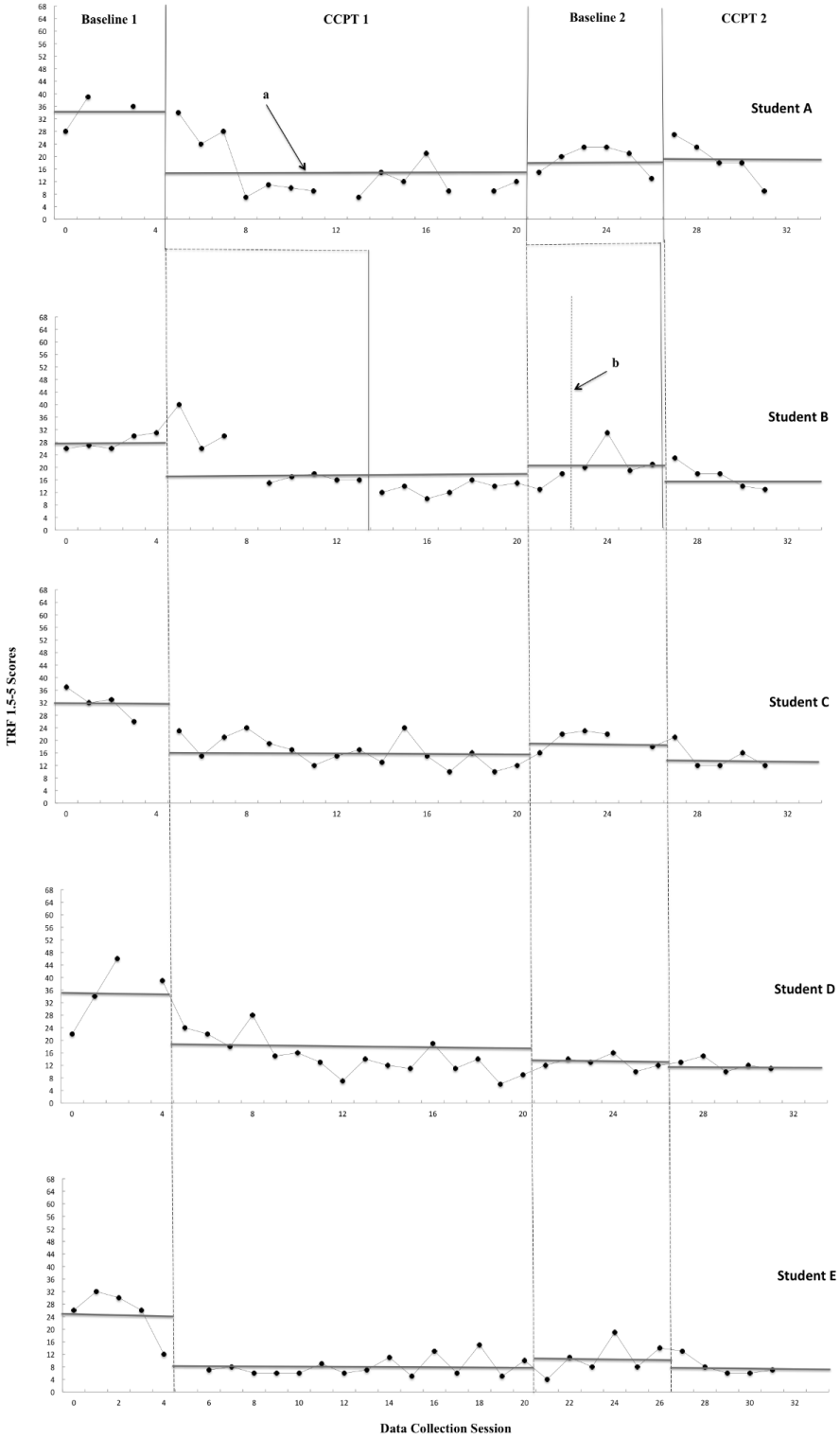

Figure 1. Student's Observer-Reported Scores in Instructional Time.
[a]Mean line of phase. [b]Increase in intervention to three times a week

Table 1

Average Scores of Students Within Student A's Phases During Group Instructional Time

	Baseline 1	CCPT 1	Baseline 2	CCPT 2
Student A	34.33	15.08	18.14	19.00
Student B[a]	28.00	18.29	19.57	17.20
Student C	32.00	16.73	18.83	14.60
Student D	35.25	15.33	12.38	12.20
Student E	25.20	8.00	10.57	8.00

Note. [a]Student B was in intervention during part of Student A's CCPT 1 and Student A's Baseline 2

Effects of CCPT on Externalizing Behaviors in Center Time

The effects of CCPT on externalizing behaviors during center time are shown in Figure 2 and Table 2. Student A received 16 sessions of CCPT, twice a week, in the first intervention and Student B received 16 sessions of CCPT total occurring twice a week until session 9 and then increased to three times a week. Figure 2 illustrates the scores from the Externalizing Behavior Subscale of the TRF 1.5-5 taken twice a week during center time for each child. Additionally, the mean score of each phase is demonstrated with a solid horizontal line on the graph. Individual results for each student will be discussed followed by the overall results for the five students included in the study.

Student A. The teacher-reported score on the TRF 1.5-5 for Student A was the highest in the class. Because of this, the teacher requested that he be chosen to begin the intervention first. During the first baseline, Student A's scores ranged from 25-38 with a mean of 32.3. During the first CCPT intervention, Student A's scores decreased, ranging from 6-24 with a mean score of 12.0. During the second baseline, Student A's scores rose slightly, ranging from 7-19 with a mean of 13.2. Finally, during the second CCPT intervention, Student A's scores rose again, ranging from 9-23 with a mean of 16.0.

Student B. Student B's teacher-reported scores on the TRF 1.5-5 was the fourth highest in the class at the beginning of the study. Once Student A's scores dropped three consecutive points in instructional time, the teacher requested that Student B be chosen to begin the intervention next. Student B completed the original multiple-baseline across students design using a staggered A-B-A design for this study. While there were 16 sessions of CCPT for Student B, there were only 12 observations for Student B in the

CCPT intervention phase, because the intervention was increased to three times a week after 9 sessions, but the observation sessions remained at two times a week. Student B's section will first include his scores during the multiple-baseline across students design examining his baseline (A), intervention (B), and maintenance phase (B). Then Student B's section will examine Student B's scores throughout Student A's reversal design that included a baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT intervention phase to examine the possibility of induction.

Student B completed multiple-baseline across students design using a baseline phase (A), the CCPT intervention (B), and a maintenance phase (A) and can be seen in Figure 2. During Student B's baseline, Student B's scores ranged from 6-28 with a mean of 16.9, but there was a descending trend in the therapeutic direction that corresponded with changes in Student A in the first CCPT intervention. During the CCPT intervention, Student B's scores decreased with a range of 2-19 with a mean of 8.8. Finally, during the maintenance phase, Student B's scores rose again ranging from 8-20 with a mean of 13.2.

It appeared the intervention did demonstrate an effect for Student B's externalizing behaviors in the multiple-baseline across students design, however, it also appeared that Student B's observer-reported scores on the Externalizing Behavior Subscale of the TRF 1.5-5 were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student B's scores were examined in relation to Student A's first baseline (A), first CCPT intervention, second baseline, and second CCPT intervention phases (Figure 2 and Table 2). During Student A's baseline phase, Student B's scores ranged from 16-28 with a mean of 23.2. During

Student A's first CCPT intervention, Student B's scores decreased, ranging from 2-26 with a mean of 10.4. During Student A's second baseline phase, Student B's scores rose slightly, ranging from 6-19 with a mean of 10.7. The ending of Student A's second baseline phase coincided with the ending of Student B's CCPT intervention phase. Finally, during Student A's second CCPT intervention, Student B's scores increased slightly, ranging from 8-20 with a mean of 13.2.

Student C. Student C did not receive the intervention, therefore, this section will examine Student C's observer-reported scores in relation to Student A's phases (See Figure 2 and Table 2). It appeared that Student C's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student C's scores were examined in relation to Student A's first baseline (A), first CCPT intervention, second baseline, and second CCPT intervention phases (Figure 2 and Table 2). During Student A's first baseline phase, Student C's scores ranged from 2-36 with a mean of 21.3. During Student A's first CCPT intervention, Student C's scores decreased, ranging from 2-30 with a mean of 9.1. During Student A's second baseline phase, Student C's scores rose again, ranging from 6-16 with a mean of 11.2. Finally, during Student A's second CCPT intervention, Student C's scores rose slightly again, ranging from 3-22 with a mean of 11.8.

Student D. Student D did not receive the intervention, therefore, this section will examine Student D's observer-reported scores in relation to Student A's phases (See Figure 2 and Table 2). It appeared that Student D's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this

possible induction, Student D's scores were examined in relation to Student A's first baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT intervention phases (B) and are illustrated in Table 2. During Student A's first baseline phase, Student D's scores ranged from 17-26 with a mean of 22.8. During Student A's first CCPT intervention, Student D's scores decreased, ranging from 4-18 with a mean of 9.9. During Student A's second baseline phase, Student D's scores decreased again, ranging from 5-13 with a mean of 8.2. Finally, during Student A's second CCPT intervention, Student D's scores increased slightly, ranging from 6-17 with a mean of 10.2.

Student E. Student E did not receive the intervention, therefore, this section will examine Student E's observer-reported scores in relation to Student A's phases (See Figure 2 and Table 2). It appeared that Student E's observer-reported scores were effected by Student A's movement in and out of the CCPT intervention. To examine this possible induction, Student E's scores were examined in relation to Student A's first baseline (A), first CCPT intervention (B), second baseline (A), and second CCPT intervention phases (B) and are illustrated in Figure 2 and Table 2. During Student A's baseline phase, Student E's scores ranged from 18-32 with a mean of 23.8. During Student A's first CCPT intervention, Student E's scores decreased, ranging from 2-23 with a mean of 8.2. During Student A's second baseline phase, Student E's scores decreased slightly, ranging from 5-13 with a mean of 7.8. Finally, during Student A's second CCPT intervention, Student B's scores increased, ranging from 8-20 with a mean of 12.2.

Overall Results. Student A and Student B received the intervention and it appeared to demonstrate a functional relation for Student A. It also seemed that Student A's movement in and out of intervention effected the externalizing behaviors of the other four male students in the class as seen in Figure 2 and Table 2. The five students included in the study mean scores decreased when Student A began the first CCPT intervention and the student's scores remained below their first baseline mean throughout the remaining phases. Student A, Student B, and Student C's mean score rose during the second baseline while Student D and Student E's mean score dropped. The five student's mean scores rose in the second CCPT intervention, however, the scores demonstrated a downward trend.

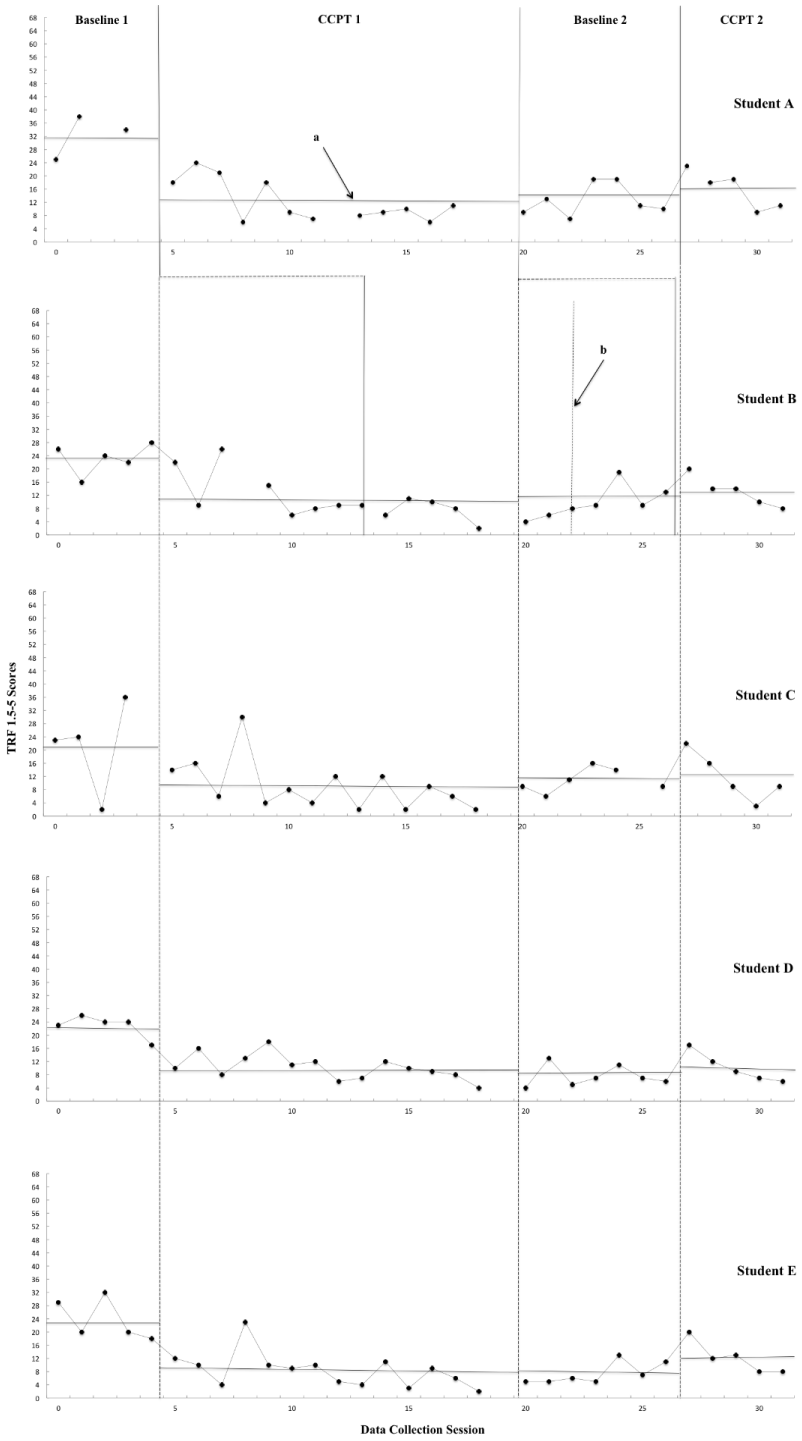

Figure 2. Student's Observer-Reported Scores in Center Time.
[a]Mean line of phase. [b]Increase in intervention to three times a week

Table 2

Average Scores of Students Within Student A's Phases During Center Time

	Baseline 1	CCPT 1	Baseline 2	CCPT 2
Student A	32.33	12.00	13.17	16.00
Student B[a]	23.20	10.36	10.67	13.20
Student C	21.25	9.07	11.20	11.80
Student D	22.80	9.87	8.17	10.20
Student E	23.80	8.20	7.83	12.20

Note. [a]Student B was in intervention during part of Student A's CCPT 1 and Student A's Baseline 2

Social Validity

The teacher completed three different measures to gather social validity data for this study. These included a social validity questionnaire and an interview of the teacher (see Table 3) examining her overall views of the effects of CCPT in her classroom, the teacher's pretest and posttest rating of each child on the TRF 1.5-5 (see Table 4) to assess her views of the effectiveness of the CCPT intervention on the externalizing behaviors of the five students, and the teacher's pretest and posttest rating of each child on the Index of Teaching Stress (see Table 5) to examine the effectiveness of the CCPT intervention on the teacher's stress.

The teacher completed a social validity questionnaire (see Table 3) and interview to examine her overall view of the CCPT intervention and how it effected her classroom environment. The teacher rated (a) the importance of the behaviors selected in assisting with classroom management, (b) the importance of the CCPT intervention, (c) the effectiveness of the CCPT intervention, and (d) using the CCPT intervention with future students. The teacher indicated she "strongly agree" that the children in the preschool needed assistance with their behaviors. She rated "agree" for the effectiveness of CCPT. She also rated the future use of CCPT with other children as "agree."

The teacher was also given the opportunity to answer open-ended questions in an interview with the researcher. The first question was, "What specific changes (if any) did you observe in regards to the student's aggressive behaviors?" The teacher reported all the students' aggressive behaviors decreased. She saw the largest decrease Student A's aggressive behaviors and Student A's aggressive behaviors decreased soon after he began

the intervention. She reported he was now engaged in cooperative play with other children where before the intervention he hit, cried, and disengaged in play behaviors when other students did not play how he wanted them to. She also reported he now used his words for communication instead of yelling, hitting and crying.

The second open-ended question was, “What specific changes (if any) did you observe in regards to the student’s hyperactive behaviors?” The teacher reported Student A showed some improvement in his hyperactive behaviors, but she reported he still had some hyperactive behaviors. She reported these included rocking back and forth during instruction time and his ability to focus fluctuated from day to day. She reported Student A’s decrease in hyperactivity did effect the other children positively and the other children seemed more focused during instructional time because Student A was a bit more focused. She also reported the reduction in Student A’s aggressive behaviors eased tension with the other students and created a more calm atmosphere where the other children could focus.

Finally, the last open-ended interview question was, “If you reported changes, how did these affect you as a teacher?” The teacher reported the reduction in aggressive and hyperactive behaviors within the students allowed her to focus more on teaching and less on behavior management. She reported this reduced her stress level and made work more enjoyable. She reported this was especially true for Student A’s behavior and the effect it had on the way she felt about him. She reported she felt fonder of him and she believed this allowed her to be more patent with him throughout the day.

Table 3

Teacher Social Validity Data

Questions	Teacher Response				
The aggressive and hyperactive concerns that were selected for interventions for this student are important.	**SA**	A	N	D	SD
At the beginning of the school year, I felt that this child needed some emotional support to be more successful at school.	**SA**	A	N	D	SD
The CCPT program was beneficial for this child.	SA	**A**	N	D	SD
The CCPT intervention program for this student was important and adequate.	SA	**A**	N	D	SD
I feel that CCPT sessions helped to improve this child's behaviors.	SA	**A**	N	D	SD
I noticed meaningful improvements in the student's aggressive behaviors after the implementation of the intervention.	SA	**A**	N	D	SD
I noticed meaningful improvements in the student's hyperactive behaviors after the implementation of the intervention.	SA	**A**	N	D	SD
Individual CCPT is a useful and appropriate intervention to decrease this student's aggressive behaviors.	SA	**A**	N	D	SD
Individual CCPT is a useful and appropriate intervention to decrease this student's hyperactive behaviors.	SA	**A**	N	D	SD
I am considering the use of CCPT with other students who have similar issues in my classroom.	SA	**A**	N	D	SD

Note. SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly disagree; Teacher answer is in bold and underlined.

The teacher also completed the TRF 1.5-5 (Table 4) on all five students during the first baseline and again after the second intervention with Student A was complete. The teacher reported Student A and Student D's score on the TRF 1.5-5 decreased. She reported Student B, Student C, and Student E's score increased.

Table 4

Teacher Reported Scores on the Teacher Report Form 1.5-5

	Pretest	Posttest
Student A[a]	42	19[b]
Student B[a]	26	35
Student C	34	37
Student D	39	29[b]
Student E	21	22

Note. Higher scores on the TRF 1.5-5 indicate higher externalizing behaviors; [a]Student received the CCPT intervention; [b]Indicates positive change in behavior

The teacher completed the Index of Teaching Stress (ITS; Table 5) for Student A, Student B, Student C, and Student D during Student A's first baseline phase. She then completed the ITS for Student A, Student B, and Student C after the second CCPT intervention phase. The teacher did not complete the ITS posttest for Student D and Student E. The teacher did not complete the posttest for Student D for personal reasons and it was determined Student E's initial scores on the TRF 1.5-5 were too low to include him in the intervention. The teacher reported her total stress score decreased for Student A. The teacher reported that the total stress score increased for Student B and Student C. This is illustrated in Table 5.

Table 5

Teacher Reported Scores on the Index of Teaching Stress

	Pretest		Posttest	
	Raw Score	Percentage	Raw Score	Percentage
Student A	161	53	144*	46
Student B	120	32	153	49
Student C	147	47	187	62
Student D	156	50	NC	NC
Student E	NC	NC	NC	NC

Note. Higher scores on the ITS indicate higher teacher stress; NC = Not Completed; ITS was not completed for Student E at pre or post test; ITS posttest was not completed for Student D

*Indicates a decrease in teacher stress

CHAPTER V: DISSCUSSION

The purpose of this study was to determine the effectiveness of child-centered play therapy (CCPT) on low-income male preschoolers' externalizing behaviors as perceived by an independent observer during group instructional time and center time. A single case reversal design was used to determine the effect of the independent variable, CCPT, on the dependent variable, externalizing behaviors. This chapter will provide an overview of the study, an overview of the results, and the conclusions of the study. Then it will discuss the contributions of the study, limitations of the study, implications of the findings for practice, recommendations for future research, and concluding remarks.

Overview of the Study

Over 20% of children and adolescents in the United States experience mental health problems at some point in their lives (Merikangas et al., 2010). This has produced a mental health crisis in the United States (Mellin, 2009) and created a drain on mental health services (Committee on School Health, 2004). Externalizing behaviors, also known as hyperactive and aggressive behaviors, have contributed to many of the diagnosis in children and adolescents. Hyperactive and aggressive behaviors normally appear in preschool, have lasting effects into the early school years (Brennan, Shaw, Dishion, & Wilson, 2012), continue to affect the middle school years (Moilanen, Shaw, & Maxwell, 2010), and can drastically impact the adult years (Wilson & Marcotte, 1996). These behaviors expressed in preschool limit children's opportunities for learning in the classroom and increases rejection from positive relationships with peers and teachers, thus affecting academic success (Moilanen, Shaw, and Maxwell, 2010). Qi and Kaiser

(2003) found preschool children from low-income families were at a higher risk of these behavior disturbances than the overall population.

Knowing the lasting affect externalizing behaviors can have on children, it is imperative that counselors intervene early. Counselors have a responsibility to strive to remove the emotional and social barriers to learning by identifying and treating these barriers early on, especially for children who are more susceptible to emotional and social barriers. Child-centered play therapy is an evidence-based therapeutic intervention that meets the developmental and emotional needs of children and can be easily implemented in a mental health facility or a school setting. Research indicated that CCPT was effective in reducing aggression and hyperactivity in elementary students (Cochran, Cochran, Fuss, & Nordling, 2010) and also was found to reduce stress in teachers (Ray, Schottelkorb, & Tsai, 2007). However, after a review of the literature, it is apparent that there is a need to expand the research conducted with preschool children and CCPT. To date, only one specific CCPT study with preschoolers was found (Bratton et al., 2013). To address this gap in the literature, this study examined the effect of CCPT on low-income male preschoolers' externalizing behaviors during center time and group instructional time.

Results Overview

An overview of the current study's results are presented and discussed in this section. First, the results for Student A are discussed for instructional time and center time. Second, the outcomes for Student B will then be discussed. Finally, the effect of Student A's change in behavior on the five identified students will be discussed.

For Student A, the introduction of CCPT suggested positive changes on the Externalizing behavior Subscale of the Teacher Report Form (C-TRF 1.5-5; Achenbach & Rescorla, 2001). Visual inspection of the data demonstrated a change in level, trend and variability across and within conditions, occurring in three different points in time indicating a functional relation was present between the introduction of CCPT and the externalizing behaviors of Student A during both instruction time and center time.

For Student B, the introduction of CCPT also suggested positive changes on the Externalizing behavior Subscale of the Teacher Report Form (C-TRF 1.5-5; Achenbach & Rescorla, 2001). While no functional relation was present, due to the design used for this student, there was a change in level, trend and variability across and within conditions. Nevertheless, it is difficult to discern if Student B's externalizing behaviors were reduced by the intervention or because of Student A's reduction in externalizing behaviors because Student B's scores follow Student A's scores throughout Student A's movement in and out of the CCPT intervention.

Concerning the other students in the study, it appeared that Student A's movement in and out of the CCPT intervention also had an effect on the three other students (Student C, Student D, Student E) during instructional time and center time. Their scores decreased when Student A began the first CCPT intervention, followed Student A's movement in and out of the CCPT intervention, and remained low throughout the study. It is important to note that the children's scores remained low during group instructional time and center time. This speaks to the effectiveness of CCPT.

Contributions of the Study

The contributions of the current study to past research are discussed in this section. First, the contributions of using a reversal design are discussed. Second, the contributions of the results with regards to the reduction of externalizing behaviors for this particular population are discussed. Finally, the contribution of this research on the classroom environment is discussed.

The Design

A major contribution of this research is that it was one of few single case designs used in counseling. Schottelkorb and Ray (2009) used a single case design to demonstrate the effectiveness of CCPT on ADHD symptoms. The current study builds on Schottelkorb and Ray's (2009) study by using a slightly different single case design that addresses the limitations listed in Schottelkorb and Ray's (2009) study. The 2009 study used a multiple treatment design to determine if CCPT alone or CCPT with another treatment would reduce ADHD symptoms. Schottelkorb and Ray (2009) state using multiple interventions as a limitation because it was difficult to determine effectiveness because of the carryover effect from one phase to another and suggested only using one intervention to determine effectiveness. The current study took this into consideration and only used CCPT as an intervention. Using only one intervention establishes that CCPT was the intervention that changed behaviors and eliminates the chance that another intervention caused the change.

Another limitation Schottelkorb and Ray (2009) discussed was the difficulty of establishing a stable baseline with the students in the study within the school setting. The

design used by Schottelkorb and Ray (2009) required the students to have a staggered start into the intervention. This was difficult because of the extreme behaviors of the students. The current study took this into consideration and used a reversal design to provide a more realistic design for the school setting while still meeting Horner et al's (2005) requirement of demonstrating at least three evidences of effects at three different points in time.

Another major contribution to the literature is the ability to determine the effectiveness of the intervention by examining when change occurs. In referring to single case design, Schottelkorb and Ray (2009) reference Morgan and Morgan (2003) and state "single-case design is the best type of research to use when trying to explain individual behavior changes, which is useful in examining the effectiveness of counseling interventions" (p. 13). In single case research, the effectiveness of an intervention is determined by how quickly the behavior changes after the intervention is implemented. In the current study, Student A's scores, in group instructional time, decreased two points the first data point after the implementation if CCPT, then decreased 10 more points at the second data point, and dropped to the score of 7 by the fourth data point, and never returned to the level of the baseline scores. In center time, his scores decreased 16 points the first data point after the intervention began, dropped 12 more points the fourth data point after the implementation of the intervention, and did not return to the first baseline scores. Through this design, it is apparent when that the change takes place within the first three data points, demonstrating the effectiveness of CCPT with low-income preschool children.

The single subject design used in this study also contributed to Bratton et al's. (2013) study by specifying when the change took place. The current study built on Bratton et al.'s (2013) study by using the same assessment, working with the same population, and implementing about the same amount of sessions. However, the current study used a different design. Bratton et al's. (2013) study examined the effectiveness of CCPT in reducing preschool children's disruptive (or externalizing) behaviors. Bratton et al's. (2013) results suggested that the experimental group demonstrated a statistically significant decrease overtime in disruptive behaviors when compared to the control group. While the results for both Bratton et al's. (2013) study and the current study are similar, the methodology of this research was different. Bratton et al.'s (2013) research used a comparison group to track the aggressive and hyperactive behaviors three times (pre-, mid-, and post-) and the current research used a single case study design to track the children's aggressive and hyperactive behaviors twice a week throughout the study. By tracking the behaviors throughout the baseline and intervention phases, the current study could pinpoint when and how quickly the change in Student A's behavior occurred, thus further adding to the body of knowledge about the impact of CCPT on the aggressive behavior of young boys.

Population

This study contributed to the literature by focusing on a different population. Schottelkorb and Ray's (2009) study focused on elementary students where as the current study focused on preschool students. Examining the effectiveness of CCPT with different populations strengthens the effectiveness of CCPT with different populations.

Schottelkorb and Ray (2009) found the intervention was effective in increasing on task behaviors. The results of the current study confirm the results of the 2009 study and built on it by examining the effectiveness of CCPT in reducing hyperactive and aggressive behaviors. Both studies demonstrate the effectiveness of CCPT.

This study also contributed to the literature by specifically focusing on preschool males from a low socioeconomic status. Preschool children from low-income families are at a higher risk of behavior disturbances than the overall population (Qi & Kaiser, 2003). Qi and Kaiser (2003) believe this is due, in part, to stressors the family experiences. During the intervention of the current study, it was apparent the preschool student who received the intervention was working through specific stressors. His themes were aggressive at first, where he fought zombies and reported he was allowed to watch "scary TV shows." The first several sessions, the researcher continuously set limits to help the student learn to control his behaviors. He would not listen to the limits as if he did not hear them. As the intervention continued, he began to demonstrate less aggressive play themes, hear the limits set, abide by the limits, and even include the researcher in his play.

Classroom Environment

This study also contributes to the future of the school counselor's role in classroom management. This is the first study that examined the impact of one child's externalizing behavior on the other students in the classroom. Working with one child fits with tier three of the Multi-Tiered System of Support that deals with implementing intensive interventions with an individual child in the classroom (Ockerman, Mason, &

Hollenbeck, 2012). Past research has indicated CCPT is an intervention that has assisted in social-emotional development for children in school (Landreth, Ray, & Bratton, 2009). Using the single subject design in the current study build on Landreth, Ray, and Bratton's (2009) study by tracking the five most aggressive students' behaviors in the classroom. The current research demonstrated that intervening with one child using CCPT was effective quickly and affected the other four participating students classroom. The teacher reported that as Student A's externalizing behaviors decreased, the other children's behaviors improved, and she could focus on teaching instead of behavior management. It seemed that providing CCPT for the child who demonstrated the highest externalizing behaviors in the classroom changed the dynamics of the four other aggressive children in the classroom.

This study also contributes to the literature by addressing ways of reducing teacher stress. Ray, Henson, Schottelkorb, Brown, and Muro (2008) found that CCPT was effective in reducing teacher stress scores on the Index of Teaching Stress (ITS; Abidin, Greene, & Konold, 2004). They found that the change in children's behavior improved the relationship, and therefore reduced teacher stress. The current study used the ITS as a social validity measure. The teacher reported that her stress scores for Student A were reduced. The researcher also conducted an interview with the teacher as a social validity measure, and the teacher confirmed that the implementation of CCPT lowered her stress with the students because it changed their behaviors and she enjoyed coming to work more.

This study included blind raters who did not know whose ratings would be used. This is a major contribution to the effectiveness of CCPT, because the raters did not know which children were receiving the intervention or which observer's scores would be used. To add to this, inter-observer agreement (IOA) was assessed for every observation and it remained over 80%, indicating the observers were viewing the children's behaviors in the same way. For the most part, IOA is not required for comparison studies. While single subject designs do require an assessment of IOA, this is the first study that assessed IOA every observation. To add to this, the observers were from different ethnicities, insuring that only more than one worldview was considered.

Finally, this study assessed for procedural reliability to determine if the researcher was actually implementing the intervention according to the standards of CCPT described in Ray's (2011) handbook. Student A's parents would not give consent for the sessions to be videoed, so several of his full sessions were observed live. To be consistent, several of Student B's full sessions were also viewed by video. This provided the opportunity for the faculty advisor to watch the researcher conduct a full session. Through this, it was determined that the researcher was consistent in implementing the CCPT intervention. This is a major contribution to the literature because most studies either do not conduct procedural reliability or do not report it. Procedural reliability demonstrated that the intervention was conducted properly and the results indicated it was effective.

Researcher Observations

This section will discuss a diversity of factors that the researcher observed that may have affected the study. First the thoughts about the teacher reported C-TRF and ITS used as social validly measures will be discussed. Then the factors that occurred within the session will be discussed.

Thoughts about Teacher's Social Validity Ratings

The teacher reported that on the C-TRF and ITS, the social validity measures, that her stress decreased with Student A and his externalizing behavior scores decreased. However, she reported her stress increased with Student B and his externalizing behavior scores increased on the social validity measures, even though the observers reported his externalizing behavior scores in instructional time and center time in the classroom actually decreased. There are a few thoughts about why this happened. As student B began the intervention, his parents separated. As the researcher implemented the intervention with Student B, his mom reported dad was abusing illegal drugs and alcohol and that dad was stating that he wanted to commit suicide in front of Student B. The teacher reported that when Student B visited with his father every other weekend, he would come to school on Monday more aggressive and began saying "potty words." While his externalizing scores remained low during this difficult time, the teacher reported that her stress with him begin to rise. This was consistent with her ratings on the Index of Teaching Stress (ITS) that indicated that her total stress score was higher with Student B at the end of the study. At the same time, her level of stress with this child did not prevent the teacher from verbally praising the intervention throughout the study.

The children who did not participate in the study may have also affected the teacher's stress levels and her scores on the final teacher reported C-TRF and ITS used for social validity measures. Five male children were selected for participation in this study, based on their scores on the C-TRF. In addition to these students, the classroom contained three male students and three female students who did not participate in the study. The teacher noted that three of these children began preschool after the study was underway. One child appeared to be autistic (although there was no formal diagnosis), one child did have a formal diagnosis of autism, and one child appeared to be severely neglected. All these children were nonverbal, not toilet trained, and demonstrated very low social skills. The teacher reported that she did not feel equipped to work with special needs students and felt like she neglected the other students. She reported that this increased her level of stress with all the children in the classroom, including the children participating in the study.

The teacher's own personal issues of social acceptability could have also been a factor that affected the initial assessments, which in turn affected the social validity measures. The teacher reported in the final interview that she rated the students lower at her initial assessment than she may have actually thought at the beginning. She reported that she believed this was due to her desire for the researcher to believe she was a "good teacher" and that the children were "good children". . As she formed a relationship with the researcher, she reported that she felt more comfortable to report a more accurate assessment of her struggles with the children. Perhaps her greater comfort and self-

awareness affected the C-TRF and ITS used as social validity measure that examined her pre and post perceptions of the students.

Finally, the teacher had some personal health concerns at the end of the study may have affected the social validity measures. Her health problems affected her overall mood, and she reported that she was not as patient with the children's behaviors. Her health could have affected her view of the children and influenced her final scores on the C-TRF and ITS used for social validity measures.

Within the Play Sessions

Both Student A and Student B's scores on the C-TRF decreased within three data points of Student A beginning the intervention in group instructional time and center time, which speaks to the effectiveness of CCPT. However, within the play sessions, it was apparent that both students continued working through issues even after the scores dropped. Student A received 16 sessions during the first intervention and five sessions during the second intervention while Student B received 16 sessions total during his intervention. At the end of the 16 sessions, it appeared within the play therapy sessions, that neither Student A nor Student B was finished with the play sessions, as evidenced by their aggression levels during the intervention time, not listening to limits set during the intervention time, and the inability to engage in nonaggressive play themes during the intervention. However, when Student A began the second intervention, his behaviors within the playtime changed. He began listening to limits and engaged in cooperative play within the session. Student B did not begin the intervention again; perhaps Student B needed more sessions to process the ever-changing environment in which he lived.

The overall structure of the space between the classroom and where the play therapy sessions were conducted also seemed to affect the children's play within the play sessions. It was not possible in this small preschool for a private space for the playroom. There was an open hallway between the classroom and the play therapy area where children in the classroom were free to walk, go to the bathroom, and get water from the water fountain. Because of this, the presence of the researcher was apparent to all the children in the classroom as evidenced by the comments of all the students who said they wanted to have "special play time" and would sometimes come to the area where the CCPT intervention was taking place. This was often disruptive to the child receiving the intervention as indicated by him running out of the play area, talking to the children who were in the hall, and hiding from the other children who were at the water fountain or bathroom.

Limitations

This section will discuss the limitations that impact the generalizability of the results of this study. This was the first single subject study conducted with low-income preschool males. However, the first limitation is the population of children selected for participation in this study. While this study demonstrated that CCPT was effective for male preschool children from low-income families, the results cannot be generalized to all children.

Another limitation is that the teacher was the only reporter of social validity. She knew which children were receiving the treatment and this could have affected her perceptions. Schottelkorb and Ray (2009) also list this as a limitation in their study. She

also felt stressed and was experiencing health issues at the end of the study, so this could have affected her.

Another limitation includes the limited time the researcher had to complete the intervention. A decision was made to increase Student B's sessions from two times a week to three times a week at session nine. This could have affected the intervention effectiveness in a positive or negative way.

The last limitation of this study includes the environment where the intervention was conducted. Because of the open construction of the preschool, there was no privacy for the room where the intervention took place. The bathroom and water fountain were beside room, and the teacher would often take children to the bathroom or the water fountain. Because of this, the teacher saw parts of the sessions and heard how the researcher related to the children. Because of this, the teacher might have altered her way of being with the children, which may have led to the children's change in behavior.

Future Research

This study demonstrated the effectiveness of CCPT with preschool children in a classroom setting. It is important to continue to build on these findings for future research in this area.

The first suggestion for future research includes using the single subject design with different populations. While many CCPT research studies have been completed, very few single subject studies have been conducted. It is important to replicate this research with elementary students, females, and children from a different SES. These different populations could deal with different stressors and this could have the capacity

to affect the impact of CCPT with this population. For example, examining the effects of CCPT with high SES children would most likely have different challenges, such as, parent expectations, children's issues within the family, or materials used in the play area.

Another suggestion includes replicating this study with an additional measure for social validity from the parent or the observer. The teacher provided the only assessment for social validity in this study, however, adding another view could be helpful in assessing the effectiveness of the intervention.

Another suggestion for future research includes replicating this study and adding a longitudinal assessment for the child's externalizing behaviors. This would determine the long-term effectiveness of CCPT on the externalizing behaviors. This could also determine if additional or booster sessions would be helpful as the child continues his academic career.

Another suggestion for future research includes assessing a child for the externalizing behaviors and other factors that allow this child to affect the behaviors of the other children in the classroom. Future research could assess both aggressive/hyperactivity and leadership and replicate the current study in terms determine if this is an effective way to change the classroom environment.

Another recommendation for future research includes examining the number of sessions preschool children need. This would include examining what was happening in the classroom as well as what was occurring inside the play session. While Student A and Student B's behaviors changed in the classroom within three data points, they were continuing to master emotional regulation within the session. While it is important for

children to change behaviors in the classroom, it is also important for them to have the time and space to work on the emotional issues within the play session.

Another recommendation for future research concerns teacher training. Child-teacher relationship training (CTRT) could be used to change how the teacher relates to the students. In CTRT teachers learn the same skills used in CCPT such as identifying the feelings of the children, limit setting, and returning responsibility. There has not been a study examining the effectiveness of CTRT using a single subject design. This study would include replicating this same study using the single case multiple baseline design using child-teacher relationship training (CTRT) as the intervention to determine the effectiveness of CTRT on the teachers' skills, the externalizing behaviors of male preschooler, and how this affects teacher stress. With a single subject design, it would be possible to track the rest of the class as well to determine the effect on the classroom as a whole. Using CTRT could help reduce the teacher's stress since teachers learn to address the feelings of the children, limit setting, and returning responsibility.

An additional recommendation for future research with teacher training could include comparing CCPT and CTRT within the same study using a single case multi-treatment design. This design is similar to the reversal design used in the current study, however two interventions are used instead of one. For example, instead of (A) baseline, (B) CCPT intervention, (A) baseline, and (B) CCPT, the design would be ABAC where (A) baseline, (B) CCPT intervention, (A) baseline, and (C) CTRT. This could be effective in determining with treatment would be more effective for students. Using both CCPT could help the child work through emotional issues while CTRT could help both

the children and reduce the teacher's stress since teachers would learn to address the feelings of the children, limit setting, and returning responsibility.

The last recommendation for future research is to replicate this study in an elementary school setting using a reversal design. Landreth, Ray, and Bratton (2009) indicate CCPT is effective for school-aged children; however, it would be informative to conduct a single case design to ascertain when changes occur. In this study, change occurred within the first three data points after the implementation of CCPT. Using a single case design, the researcher could track behavior scores throughout the study to determine when the reduction in externalizing behaviors occurs in the elementary classroom. Second, using the single subject design could answer, what impact does CCPT have on the other students in the classroom? Again, when using this design, it is easy to track the changes in behavior with each child in the classroom.

Implications for Practice and Counselor Education

The review of the literature clearly demonstrated that preschool children's externalizing behaviors affect their later social, emotional and academic development and are harder to teach. Externalizing behaviors affect the way teachers view children, because these behaviors caused significant stress to the teacher so children with these behaviors were more frustrating to teach (Green, Beszterczey, Katzenstein, Park, & Goring, 2002). However, there was a lack of research examining the effect of CCPT on low-income preschool males exhibiting externalizing behaviors. The implications of these finding are important for counselors working in schools and for counselor educators.

School Setting

First, the findings of this study provide school counselors with information about an intervention that could alleviate current and future issues that low-income male preschoolers face. Again, working with one child fits with tier three of the Multi-Tiered System of Support that deals with implementing intensive interventions with an individual child in the classroom (Ockerman, Mason, & Hollenbeck, 2012). After the implementation of CCPT with Student A, his scores decreased in both group instructional time and center time within the first few data points. He listened to the teacher better and the amount of hitting, and crying was reduced. He was able to sit and work on the schoolwork the teacher gave him.

This research also provides information to school counselors about how they could use CCPT for classroom management and reducing teacher stress and burnout. This study indicated CCPT is effective in changing the dynamics of the whole classroom. The implication of this is that it could change the way school counselors work with teachers in classroom management. Past research indicated student's externalizing behaviors increases teacher stress (Friedman-Krauss, Raver, Neuspiel, & Kinsel, 2014), and teacher stress was associated with teacher emotional exhaustion and burnout (Jennings & Greenberg, 2009), which affected classroom emotional climate (Downer, Sabol, & Hamre, 2010). The teacher in this study reported that as Student A's externalizing behaviors decreased, the dynamics of the classroom changed and she was able to teach more effectively. She reported this before any other student began the intervention. She also reported her work was more enjoyable now that the class was more

manageable. This statement indicates that the classroom dynamics did affect this teacher's stress and burnout. If counselors can assist in changing the dynamics of the classroom by working with one child, then counselors can assist in reducing teacher stress and burnout. Working with one child, as opposed to all the children who exhibit externalizing behaviors, is a more feasible option, more cost effective, and time effective to attempt to change the classroom emotional climate and teacher stress.

This study also demonstrates the importance of having counselor access for children in preschools. This is especially true of smaller low-income preschools with early education programs. Larger preschool programs, such as Headstart, are a part of the public school program and have access to this service. However, smaller preschools do not have this access. It is important to provide all children with the services needed to support children insure success in school entry and beyond.

Finally, this research establishes a research design that can be used with their everyday jobs. Many times counselors do not have the funding or the number of participants to conduct a comparison study. With the single subject design, a counselor can conduct the research within the classroom setting with a limited number of children. This provides counselors the opportunity to assess behaviors and see the impact of their work.

Counselor Educators

The findings of this study can be used to assist counselor educators and supervisors in training new counseling students interested in working with young children. The effectiveness of CCPT in this study provided a model of therapy that

should be taught to students interested in working with young children. Any counselor who is interested in working with preschool aged children should be required to focus on CCPT by learning about child development, the theory, the techniques, and then practicing with preschool aged children. Working with children who are of preschool age is very different from working with elementary aged children so counselor educators can assist new counselors in implementing the skills and understanding the theory behind the skills.

This study also provides counselor educators a model for research to assess the effectiveness of CCPT. The single subject design allows counselor educators, counseling students, and counselors to monitor the effectiveness of their work because the behaviors are being assessed throughout the study. The stakeholders can observe where change takes place and if changes need to be made while the data is being collected. Because of this, it is important to consider the single subject design as a part of education for future counselors.

Concluding Remarks

A review of the research indicated there was little research examining the effect of CCPT on preschool children. Additionally, no research was found examining the effect of CCPT on the whole classroom. This study followed the recommendations for single subject design set forth by Horner et al. (2005) to insure fidelity of the results. The results demonstrated a functional relation between CCPT and externalizing behaviors of low-income male preschoolers, provided a model for working with young children in the

classroom, and demonstrated an effective model of research for counselors in the school settings.

The implications of this research can change the life trajectory of low-income males. These three and four years old children face a system that is often against them. They are a vulnerable population that does not have the resources to help themselves. It is the responsibility of adults around them to assist with this. Helping these young boys decrease their externalizing behaviors may enable them to succeed throughout school to become all they can be. This will not only change their world, but it will change the world around them for the positive.

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APPENDIX A: EXTERNALIZING BEHAVIOR SUBSCALE OF THE CAREGIVER/TEACHER REPORT FORM (C-TRF 1.5-5)

Student: _____ Observer: _____ Date: _____

Center Time____ Group Instruction Time ____

Be sure to answer all items on the following scale.

0 = Not True (as far as you know) 1 = Somewhat/Sometimes True 2 = Very True/Often True

1. Can't concentrate or pay attention - ATT	0	1	2
2. Can't sit still, restless or hyperactive - ATT	0	1	2
3. Can't stand waiting; wants everything right now - AGG	0	1	2
4. Cruel to Animals	0	1	2
5. Defiant - AGG	0	1	2
6. Demands must be met immediately - AGG	0	1	2
7. Destroys his/her own things - AGG	0	1	2
8. Destroys property belonging to others - AGG	0	1	2
9. Disobedient - AGG	0	1	2
10. Cruelty, bullying, or meanness to others – AGG	0	1	2
11. Difficulty following directions – ATT	0	1	2
12. No Guilt	0	1	2
13. Disturbs other children – AGG	0	1	2
14. Frustrated - ATT	0	1	2
15. Gets in many fights – AGG	0	1	2
16. Hits others – AGG	0	1	2
17. Gets hurt; has accidents – AGG	0	1	2
18. Angry moods- AGG	0	1	2
19. Fails to carry out assigned tasks – ATT	0	1	2
20. Fidgets – ATT	0	1	2
21. Physically attacks people- AGG	0	1	2
22. Clumsy – ATT	0	1	2
23. Punishment doesn't change his/her behavior. - AGG	0	1	2
24. Quickly shifts from one activity to another - ATT	0	1	2
25. Inattentive – ATT	0	1	2
26. Screams a lot- AGG	0	1	2
27. Selfish or won't share- AGG	0	1	2
28. Not Liked	0	1	2
29. Stubborn, sullen, or irritable- AGG	0	1	2
30. Teases A lot - AGG	0	1	2
31. Temper tantrums or hot temper - AGG	0	1	2
32. Uncooperative- AGG	0	1	2
33. Wants a lot of attention- AGG	0	1	2
34. Wanders – ATT	0	1	2
Totals			

Total Score: _____

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APPENDIX B: PLAY THERAPY SKILLS CHECKLIST (PTSC)

Therapist: _____ Student Code: _____
Observer: _____ Session # & Time: _____

Therapist Non-Verbal Communication		Too Much	Appro-priate	Need More	None	Therapist Responses/ Examples	Supervision Comments
Lean Forward/Open							
Appeared Interested							
Relaxed Comfortable							
Tone/Expression Congruent with Child's Affect							
Succinct/Interactive							
Rate of Responses							
Therapist Responses:	# of Responses	Too Much	Appro-priate	Need More	None	Therapist Responses/ Examples	Other Possible Responses
Tracking Behavior							
Reflecting Content							
Reflecting Feelings							
Facilitating Decision Making/ Responsibility							
Facilitating Creativity/Spontaneity							
Esteem Building/ Encouraging							
Facilitating Relationship							
Limit-Setting							
Non-CCPT Responses							

Child Made Contact/Connectedness: Yes No Examples:
Identified Themes:
Therapist's Strengths:
Areas for Growth:

APPENDIX C: THE INDEX OF TEACHING STRESS (ITS)

1 Never Stressful	2 Rarely Stressful	3 Sometimes Stressful	4 Often Stressful	5 Very Often Stressful

1. This student distracts other students in my class.
2. When playing, this student doesn't often giggle or laugh.
3. This student doesn't seem to smile as much as most students.
4. This student is not able to do as much as most other students in my class.
5. It takes a long time and is very hard for this student to get used to new things.
6. This student does things that bother me just to be mean.
7. This student seems to cry or fuss more than most students.
8. This student is usually in a bad mood.
9. This student is very moody and easily upset.
10. This student reacts very strongly when something happens that he/she doesn't like.
11. This student gets upset easily over the smallest things.
12. It is much harder to keep this student on a routine than others in my class.
13. I have found that getting this student to follow directions is much harder than for most students.
14. This student is much more of a problem than most of my other students.
15. This student makes more demands on me than most of my other students.
16. This student is so active it exhausts me.
17. This student is disorganized and easily distracted.
18. When this student wants something, he/she persists in getting it.
19. Compared to most, this student has more difficulty concentrating and paying attention.
20. This student often cannot stay occupied with an activity or project for more than 10 minutes.

1	2	3	4	5
Never Stressful	Rarely Stressful	Sometimes Stressful	Often Stressful	Very Often Stressfu

21. This student wanders around the classroom more than most others.
22. This student is much more active than most others.
23. This student squirms and fidgets a great deal.
24. This student has significant learning disabilities.
25. In many ways, this student seems to have forgotten past learning and gone back to doing things characteristic of younger students.
26. This student doesn't seem to learn as quickly as most students.
27. Compared to the average student, this student has a great deal of difficulty adjusting to changes in the class schedule.
28. This student misbehaves when left with a substitute.
29. This student easily notices and overreacts to loud noises and bright lights.
30. When upset, this student is difficult to calm.
31. This student is always clinging to me.
32. This student does not socialize well with other students.
33. This student is very withdrawn.
34. This student has a lot of somatic (physical) complaints.
35. This student seems very worried and nervous.
36. This student seems to feel worthless and unloved.
37. This student is often teased by other students.
38. This student exhibits strange behaviors and seems to have strange ideas.
39. This student seems to have no guilt after misbehavior.
40. This student steals and lies.

1 Never Stressful	2 Rarely Stressful	3 Sometimes Stressful	4 Often Stressful	5 Very Often Stressfi

41. This student is frequently out of control.

42. This student is argumentative and defiant.

43. This student can be very destructive.

44. This student is very aggressive (e.g., hits, bites, kicks other students).

45. This student is self-abusive (e.g., biting self, head-banging).

46. This student makes lewd or obscene gestures or engages in inappropriate sexual behavior (e.g., masturbating).

47. This student throws tantrums.

PART B

Instructions:

We are interested in how distressed you feel about your interactions with the student named previously.

Fill in "**1**" if the statement is **Never Distressing** ● ② ③ ④ ⑤
Fill in "**2**" if the statement is **Rarely Distressing** ① ● ③ ④ ⑤
Fill in "**3**" if the statement is **Sometimes Distressing** ① ② ● ④ ⑤
Fill in "**4**" if the statement is **Often Distressing** ① ② ③ ● ⑤
Fill in "**5**" if the statement is **Very Distressing** ① ② ③ ④ ●

For example, if you are sometimes distressed that the student is often out of their seat, you would fill in **3** in response to the following statement:

1. This student is often out of his/her seat. 1. ① ② ● ④ ⑤

If you make a mistake or want to change your answer, ***DO NOT ERASE***. Instead draw an **X** through the answer you want to change and then fill in the correct answer:

1. This student is often out of his/her seat. 1. ● ② ✖ ④ ⑤

1	2	3	4	5
Never Distressing	Rarely Distressing	Sometimes Distressing	Often Distressing	Very Distressing

48. I feel trapped by my responsibilities as this student's teacher.

49. I feel that this student negatively affects my ability to enjoy my life outside of school.

50. Nothing I do seems to help with this student.

51. I feel that this student adversely affects my ability to enjoy teaching.

52. This student rarely does things for me that make me feel good.

53. I feel that this student does not like me and does not want to be close to me.

54. When I expend extra energy for this student, I get the feeling that my efforts are not appreciated very much.

55. I do not feel as close to or as warmly about this student as I would like.

56. This student does things that bother me a great deal.

1	2	3	4	5
Never Distressing	Rarely Distressing	Sometimes Distressing	Often Distressing	Very Distressing

57. This student prevents me from doing some of the things I would like to do with my whole class.
58. I feel embarrassed by this student's behavior when I am in public.
59. Having this student in my class is frustrating.
60. Interacting with this student's parents is frustrating.
61. I feel that I should be in better control of this student than I am.
62. This student makes my school day less enjoyable than I would like.
63. I feel that I need more help with this student than I am being provided.
64. I have the feeling that I cannot handle this student very well.
65. When it comes to this student, I feel that I am not being a very good teacher.
66. I feel embarrassed by this student's lack of progress in my class.
67. I have doubts about my ability to handle being this student's teacher.
68. I am exhausted by the energy it takes to monitor and manage this student.
69. Interacting with this student makes me question my decision to be a teacher.
70. I worry that this student will adversely affect the good reputation I have achieved as a teache
71. I feel that this student would be more successful in my classroom if I were provided with an aide.
72. I find myself giving up more of my time to meet this student's needs than most others in my class.
73. Having this student in my class increases the problems I have with other students.
74. I feel that I am not doing as well as other teachers with this student.
75. I am intolerant of the challenges this student presents.
76. When I am having a problem with this student, I do not feel that I can count on the principal (or assistant principal) supporting me.
77. I feel frustrated about the way I act and feel toward this student.

1	2	3	4	5
Never Distressing	Rarely Distressing	Sometimes Distressing	Often Distressing	Very Distressing

78. I wish I had someone to turn to for guidance in dealing with this student.

79. It drains my energy to constantly seek and create new ways to teach this student.

80. I feel that I have received much less support/help with this student than I expected.

81. I do not feel that I am handling this student as well as other teachers would.

82. I feel frustrated that this student is not being successful in my classroom.

83. I do not enjoy teaching this student.

84. I feel embarrassed by this student.

85. This student's parents call me to tell me they are unhappy about something I've done with this student.

86. I feel harassed by this student's parents.

87. This student's parents don't seem concerned about their child's behavior at school.

88. I feel this student comes from an unsupportive home situation.

89. I am unable to agree with this student's parents about how to best handle the student's problem behavior at school.

90. This student takes my attention away from other students in my class.

Abidin, R. R., Green, R. W. & Konold, T. R. (2004). Index of Teaching Stress. Lutz, FL: Psychological Assessment Resources.

APPENDIX D: CCPT SOCIAL VALIDITY QUESTIONAIRE

Student: _____ Date: _____

This questionnaire consists of 18 items. For items 1through 10, you need to indicate the extent to which you agree or disagree with each statement. Please indicate your response to each item by circling one of the five responses to the right. For items 10 through 14, please share any additional responses you might have.

Questions	Responses
1. The aggressive and hyperactive concerns that were selected for interventions for this student are important.	Strongly Agree Agree Neutral Disagree Strongly Disagree
2. At the beginning of the school year, I felt that this child needed some emotional support to be more successful at school.	Strongly Agree Agree Neutral Disagree Strongly Disagree
3. The CCPT program was beneficial for this child.	Strongly Agree Agree Neutral Disagree Strongly Disagree
4. The CCPT intervention program for this student was important and adequate.	Strongly Agree Agree Neutral Disagree Strongly Disagree
5. I feel that CCPT sessions helped to improve this child's behaviors.	Strongly Agree Agree Neutral Disagree Strongly Disagree
6. I noticed meaningful improvements in the student's aggressive behaviors after the implementation of the intervention.	Strongly Agree Agree Neutral Disagree Strongly Disagree
7. I noticed meaningful improvements in the student's hyperactive behaviors after the implementation of the intervention.	Strongly Agree Agree Neutral Disagree Strongly Disagree
8. Individual CCPT is a useful and appropriate intervention to decrease this student's aggressive behaviors.	Strongly Agree Agree Neutral Disagree Strongly Disagree
9. Individual CCPT is a useful and appropriate intervention to	Strongly Agree Agree Neutral Disagree Strongly Disagree

decrease this student's hyperactive behaviors.	
10. I am considering the use of CCPT with other students who have similar issues in my classroom.	Strongly Agree Agree Neutral Disagree Strongly Disagree

11. What specific changes (if any) did you observe in regards to the student's aggressive behaviors?

12. What specific changes (if any) did you observe in regards to the student's hyperactive behaviors?

13. If you reported changes, how did these affect you as a teacher?

14. Additional Comments:

Source: Adapted from "Effects Of Child-Centered Play Therapy on Social Skills, Academic Achievement, and Self-Concept of Children with Learning Disabilities: A Single-Case Design" by J. Geddes, 2015, Unpublished Dissertation, The University of North Carolina at Charlotte, pp. 81-85.

Source: Adapted from "Functional Assessments and Individualized Intervention Plans: Increasing the Behavior Adjustment of Urban Learners in General and Special Education Settings" by Y. Lo, 2003, Unpublished Dissertation, The Ohio State University, pp. 289-295.

APPENDIX E: SCHOOL APPROVAL LETTER

Kids Club Learning Center
6610 Ware Rd
Charlotte, NC 28212
704-531-1116

September 27, 2016

To Whom It May Concern:

Please accept this letter as verification that Christa Phipps is able to visit and can complete any study requirements at Kids Club Learning Center.

Please feel free to contact me should you need further information.

Lisa Eddins-Smith
Lisa Eddins-Smith
Owner and Administrator

APPENDIX F: RECRUITMENT FLYER

UNC CHARLOTTE
College of Education

IS YOUR CHILD HAVING BEHAVIORAL DIFFICULTIES IN PRESCHOOL? DOES HE GET IN TROUBLE AT SCHOOL? ARE YOU WONDERING WHAT TO DO?

You are invited to participate in a research study entitled The Effect of Child-Centered Play Therapy on the Externalizing Behaviors of Minority Male Preschoolers during Center Time and Group Instructional Time: A Single-Case Design Study. The purpose of this study is to understand the effect individual, child-centered play therapy (CCPT) has on the aggressive and/or hyperactive behaviors of preschool males. Preschool is a difficult time to for parents when their own children or children in the classroom are aggressive or hyperactive. As a result, children and parents tend to experience anxiety. It is hoped that this study will assist with understanding the process parents and teachers experience and this will inform how counselors can provide helpful services surrounding this issue.

PLEASE CONTACT CHRISTA PHIPPS (christaphipps@gmail.com or 704-807-4089) IF YOU ARE WILLING FOR YOUR CHILD TO PARTICIPATE IN A RESEARCH PROJECT FOCUSED ON REDUCING AGGRESSION AND HYPERACTIVITY THROUGH CHILD-CENTERED PLAY THERAPY.

Call 704-807-4089 for more information.

APPENDIX G: INFORMED CONSENT – PARENTAL

UNC CHARLOTTE
College of Education
University of North Carolina at Charlotte

Project Title and Purpose:
You are invited to participate in a research study entitled The Effect of Child-Centered Play Therapy on the Externalizing Behaviors of Minority Male Preschoolers During Center Time and Group Instructional Time: A Single-Case Design Study. The purpose of this study is to assess the effect of individual, child-centered play therapy (CCPT) on the externalizing behaviors of preschool minority males. Preschool is a difficult time to for parents when their own children or children in the classroom are aggressive or hyperactive. As a result, children and parents tend to experience anxiety. It is hoped that this study will assist with understanding the process parents and teachers experience and this will inform how counselors can provide helpful services surrounding this issue.

Investigator(s):
This study is being conducted by Christa B. Phipps with Dr. Phyllis Post as the supervising professor in the Department of Counseling at UNC Charlotte.

Eligibility:
All 10 of the male children in the three and four year old class are eligible for this study. Five of the 10 males in the class will be chosen to participate in the CCPT intervention based on the teacher's scores on an assessment that scores aggressive and hyperactive behaviors.

Description of Participation:
All the male children in the classroom will be observed twice a week and their behaviors rated for around 16 - 20 weeks. During this time, several children will be selected to participate in 16 sessions of Child-centered Play Therapy (CCPT) over an eight-week period. If selected, your child will not miss any instructional time, and will get to have a 30-minute playtime, twice a week with a trained therapist. This is a time where your child can work on his/her self-esteem and social skills in a fun, playful environment. This is also a time where your child can have fun one-on-one attention that most children enjoy. If your child is not selected for the CCPT, he will go about his day like normal.

The CCPT sessions will take place in a separate room from the rest of the class and will be video recorded either on a computer or IPad device that is not connected to the cloud. The recordings will be viewed by Dr. Phyllis Post to insure the reliability of the intervention. All the recordings will be destroyed once the study has been completed.

Length of Participation:

Your child's participation in this project will take around 16 weeks. If your child does not participate in the CCPT, he/she will go about his/her normal daily routine. If your child does participate in the CCPT, he/she will meet with Christa Phipps twice a week for eight weeks. All the children will be observed for the full duration of the study.

Risks and Benefits of Participation:
The benefits of participation in this study include the opportunity for your child to receive an intervention that potentially will boost his/her self-esteem and assist with any behavior or social issues that your child may have. This will be provided for free from a Licensed Professional Counselor who has been working with children for 19 years. The results of the study will inform counselors, social workers and other helping professionals of the needs of this population. There are no costs to you that are associated with participating in this study.

The risks associated with this study are the normal risks associated with any type of counseling. This includes worsening of your child's behaviors as he/she works through issues, or behaviors not changing. There may also be risks that are currently unforeseeable. If the need for counseling support arises, the researcher will assist you in securing the needed support.

Volunteer Statement:
Your child is a volunteer. The decision for your child to participate in this study is completely up to you. You and your child have a right to confidentiality. At anytime you can choose to stop participation in this study. If you decide not to participate or stop once you have started, you will not be treated any differently.

Anonymity/Confidentiality:
The following steps will be taken to ensure anonymity: The data collected by the researchers will not contain any identifying information or any link back to you/your child or your participation in this study. The researchers will use pseudonymes, assigned at our first meeting, to protect your identity and the identity of any third party mentioned. The researcher also will either change or not use any information that could lead to your identity being revealed.
The following steps will be taken to ensure confidentiality: All notes, assessments, and the research product itself will contain the assigned name rather than your child's real name. All sensitive information pertaining to this research, including your child's real name and identifying information, the recordings of the interventions and the assessments will be kept under two locks at the office of the primary investigator.

Fair Treatment and Respect:
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office (704-687-1871) or uncc-irb@uncc.edu if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Christa B. Phipps at 704-807-4089 or Dr. Phyllis Post at 704-687-8972.

Participant Consent:
I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age and I agree to for my child to participate in this research project. Furthermore, I agree to allow the researcher to digitally tape the CCPT session for potential review by her supervisor, Dr. Phyllis Post. I also agree to allow all the data to be used for future research with the understanding that

confidentiality for my child's identity will be maintained to the highest standards. I understand that I will receive a copy of this form after the Principal Investigator and I have signed it.

Signatures:

_____

Participant Name (PLEASE PRINT):

_____ _____

Participant's Parent/Guardian Signature DATE

_____

Relation to the Participant

_____ _____

Researcher Signature: Christa B Phipps DATE

APPENDIX H: INFORMED CONSENT – TEACHER

Project Title and Purpose:
You are invited to participate in a research study entitled The Effect of Child-Centered Play Therapy on the Externalizing Behaviors of Minority Male Preschoolers During Center Time and Group Instructional Time: A Single-Case Design Study. The purpose of this study is to understand the effect individual, child-centered play therapy (CCPT) has on the aggressive and/or hyperactive behaviors of preschool males. Preschool is a difficult time to for parents when their own children or children in the classroom are aggressive or hyperactive. As a result, children and parents tend to experience anxiety. It is hoped that this study will assist with understanding the process parents and teachers experience and this will inform how counselors can provide helpful services surrounding this issue.

Investigator(s):
This study is being conducted by Christa B. Phipps with Dr. Phyllis Post as the supervising professor in the Department of Counseling at UNC Charlotte.

Eligibility:
All the male children in the three and four year old class are eligible for this study.

Description of Participation:
All the children in your classroom will be observed twice a week for around 16 - 20 weeks. Your participation will be completing observation forms on the children twice, paper and pencil assessments, and/or an interview with the lead researcher (Christa Phipps) at the beginning of the study and at the end of the study.

Length of Participation:
Your participation in this project will take around 16 - 20 weeks.

Risks and Benefits of Participation:
The benefits of participation in this study include the opportunity for the children to receive an intervention that potentially will boost his/her self-esteem and assist with any behavior or social issues that the child may have in your classroom. The results will also add to the current body of literature and will inform counselors, social workers and other helping professionals of the needs of this population. There are no costs to you that are associated with participating in this study.

The risks associated with this study are the normal risks associated with any type of counseling. This includes worsening of the child's behaviors as he/she works through issues, resulting in the

child acting aggressively toward you. There may also be risks that are currently unforeseeable. If the need for counseling support arises, the researcher will assist you in securing the needed support.

Volunteer Statement:
You are a volunteer. The decision to participate in this study is completely up to you. You have a right to confidentiality. At anytime you can choose to stop participation in this study. If you decide not to participate or stop once you have started, you will not be treated any differently.

Anonymity/Confidentiality:
The following steps will be taken to ensure anonymity: The data collected by the researchers will not contain any identifying information or any link back to you or your participation in this study. The researchers will use pseudonymes, assigned at our first meeting, to protect your identity and the identity of any third party mentioned. The researcher also will either change or not use any information that could lead to your identity being revealed.

The following steps will be taken to ensure confidentiality: All notes, assessments, and the research product itself will contain the assigned name rather than your real name. All sensitive information pertaining to this research, including your real name and identifying information, the recordings of the interventions and the assessments will be kept under two locks at the office of the primary investigator. The results will be shared with you upon final analysis.

Fair Treatment and Respect:
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office (704-687-1871) or uncc-irb@uncc.edu if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Christa B. Phipps at 704-807-4089 or Dr. Phyllis Post at 704-687-8972.

Participant Consent:
I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age and I agree to participate in this research project. I also agree to allow all the data to be used for future research with the understanding that confidentiality for my identity will be maintained to the highest standards. I understand that I will receive a copy of this form after the Principal Investigator and I have signed it.

_____
Participant Name (PLEASE PRINT):

_____ _____
Participant's Parent/Guardian Signature DATE

_____
Relation to the Participant

_____ _____
Researcher Signature: Christa B Phipps DATE

APPENDIX I: INFORMED CONSENT – INDEPENDENT OBSERVER

UNC CHARLOTTE
College of Education

Project Title and Purpose:
You are invited to participate in a research study entitled The Effect of Child-Centered Play Therapy on the Externalizing Behaviors of Minority Male Preschoolers During Center Time and Group Instructional Time: A Single-Case Design Study. The purpose of this study is to understand the effect individual, child-centered play therapy (CCPT) has on the aggressive and/or hyperactive behaviors of preschool males. Preschool is a difficult time to for parents when their own children or children in the classroom are aggressive or hyperactive. As a result, children and parents tend to experience anxiety. It is hoped that this study will assist with understanding the process parents and teachers experience and this will inform how counselors can provide helpful services surrounding this issue.

Investigator(s):
This study is being conducted by Christa B. Phipps with Dr. Phyllis Post as the supervising professor in the Department of Counseling at UNC Charlotte.

Eligibility:
All the male children in the three and four year old class are eligible for this study.

Description of Participation:
You will observe all the male children in a preschool classroom twice a week and rate behaviors for around 16 - 20 weeks. Your participation will be completing observation forms on the children twice a week and working with the lead researcher (Christa Phipps) until the observations and ratings are complete.

Length of Participation:
Your participation in this project will take approximately around 16 - 20 weeks.

Risks and Benefits of Participation:
The benefits of participation in this study include the opportunity for you to learn about child behavior and participate in a study that will add to the current body of literature that will inform counselors, social workers and other helping professionals of the needs of this population. There are no costs to you that are associated with participating in this study.

The risks associated with this study are the normal risks associated with any type of counseling. This includes worsening of the child's behaviors as he/she works through issues, resulting in the

child acting aggressively toward you. There may also be risks that are currently unforeseeable. If the need for counseling support arises, the researcher will assist you in securing the needed support.

Volunteer Statement:

You are a volunteer. The decision to participate in this study is completely up to you. You have a right to confidentiality. At anytime you can choose to stop participation in this study. If you decide not to participate or stop once you have started, you will not be treated any differently.

Anonymity/Confidentiality:

The following steps will be taken to ensure anonymity: The data collected by the researchers will not contain any identifying information or any link back to you or your participation in this study. The researchers will use pseudonymes, assigned at our first meeting, to protect your identity and the identity of any third party mentioned. The researcher also will either change or not use any information that could lead to your identity being revealed.

The following steps will be taken to ensure confidentiality: All notes, assessments, and the research product itself will contain the assigned name rather than your real name. All sensitive information pertaining to this research, including your real name and identifying information, the recordings of the interventions and the assessments will be kept under two locks at the office of the primary investigator. The results will be shared with you upon final analysis.

Fair Treatment and Respect:

UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office (704-687-1871) or uncc-irb@uncc.edu if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Christa B. Phipps at 704-807-4089 or Dr. Phyllis Post at 704-687-8972.

Participant Consent:

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age and I agree to participate in this research project. Furthermore, I also agree to allow all the data to be used for future research with the understanding that confidentiality for my identity will be maintained to the highest standards. I understand that I will receive a copy of this form after the Principal Investigator and I have signed it.

_____

Participant Name (PLEASE PRINT):

_____ _____

Participant's Parent/Guardian Signature DATE

_____

Relation to the Participant

_____ _____

Researcher Signature: Christa B Phipps DATE

APPENDIX J: PARENTAL CONSENT FOR CHILDREN USED TO OBTAIN INTER-OBSERVER AGREEMENT

UNC CHARLOTTE
College of Education

Project Title and Purpose:
Your child is invited to participate in a research study entitled: The Effect of Child-Centered Play Therapy on the Externalizing Behaviors of Minority Male Preschoolers During Center Time and Group Instructional Time: A Single-Case Design Study. Your child will not participate in the actual study; instead, your child will be used to train the raters for the actual study to ensure the raters use the rating assessment consistenly and reliably. This rating will be done when your child is in his classroom during center time and/or instruction time. The rater will be unobtrusive in the class, and your child will not be aware that he is being rated.

In addition, we request that your child participate by allowing that your child's counseling sessions with Christa Phipps are video recorded. Again, your child will not participate in the actual study. In this case, the work of the counselor, Christa Phipps, will be assessed to ensure that she is providing consistent and reliable counseling services. Your child's behaviors will not be assessed during the counseling sessions.

The purpose of this study is to understand the impact individual, child-centered play therapy (CCPT) has on the aggressive and/or hyperactive behaviors of preschool males. Preschool is a difficult time to for parents when their own children or children in the classroom are aggressive or hyperactive. As a result, children and parents tend to experience anxiety. It is hoped that this study will assist with understanding the process parents and teachers experience and will inform how counselors can provide helpful services to children, parents, and teachers.

Investigator(s):
This study is being conducted by Christa B. Phipps with Dr. Phyllis Post as the supervising professor in the Department of Counseling at UNC Charlotte.

Eligibility:
Children at Hickory Grove Preschool who are clients of Christa Phipps are eligible to participate.

Description of Participation:
There are two ways your child will participate:

First, your child will be observed by two counseling interns under the supervision of Christa Phipps three to five times to teach the interns how to rate preschoolers' behaviors. There will be no interaction with your child with the observers, and your child will go about their normal day.

Second, your child will be recorded during their normal counseling times with Christa Phipps three to five times. Christa Phipps and Dr. Phyllis Post will view a five to seven minute clip of the session to ensure that the counseling services provided are reliable. The counseling services your child will receive will not change in any way other than being video recorded.

Length of Participation:
Your participation in this project will take approximately around 3 - 5 weeks.

Risks and Benefits of Participation:
The benefit of participation is that it will be used to train two independent observers for this research project thereby giving you the chance to participate in a study that will add to the current body of literature that will inform counselors, social workers and other helping professionals of the needs of this population. There are no costs to you that are associated with participating in this study.

The risks associated with participation include your child knowing they are being video recorded during sessions and may feel a bit unsure about this. There also may be risks that are currently unforeseeable.

Volunteer Statement:
You and your child are a volunteer. The decision to participate in this study is completely up to you. You have a right to confidentiality. At anytime you can choose to stop participation. If you decide not to participate or stop once you have started, you will not be treated any differently.

Anonymity/Confidentiality:
The following steps will be taken to ensure anonymity: The data collected by the researchers will not contain any identifying information or any link back to your child's participation in this study. The researchers will use pseudonymes, assigned at our first meeting, to protect your identity and the identity of any third party mentioned. The researcher also will either change or not use any information that could lead to your child's identity being revealed.

The following steps will be taken to ensure confidentiality: All assessments will contain the assigned name rather than your real name. All sensitive information pertaining to this research, including your child's name and identifying information, the recordings of the interventions and the assessments will be kept under two locks at the office of the primary investigator.

Fair Treatment and Respect:
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office (704-687-1871) or uncc-irb@uncc.edu if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Christa B. Phipps at 704-807-4089 or Dr. Phyllis Post at 704-687-8972.

Participant Consent:
I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age and I agree to my child to participate in this research project. I understand this consent is to allow Christa Phipps to record my child's sessions with her; otherwise, nothing within the therapeutic relationship will change. Furthermore, I also agree to allow all the data to be used for future

research with the understanding that confidentiality for my child's identity will be maintained to the highest standards. I understand that I will receive a copy of this form after the Principal Investigator and I have signed it.

Signatures:

_____

Participant Name (PLEASE PRINT):

_____ _____

Participant's Parent/Guardian Signature DATE

_____

Relation to the Participant

_____ _____

Researcher Signature: Christa B Phipps DATE